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14. ABSTRACT An analysis of the MHS Strategy formulation process utilizing the Balanced Scorecard framework identifies gaps between the theoretical model and the actual steps taken. Successful implementation of the strategic plan is not a given. Many factors will influence the ultimate success or failure of senior leadership's current strategic management efforts. The Balanced Scorecard provides a framework to balance financial objectives with other equally important perspectives, overcoming the inherent overemphasis on performance measurement governing the federal sector. While the Balanced Scorecard approach provides a valid theoretical construct for strategic planning, political, financial, legal, and organizational relationships significantly impact effective implementation. Continued development of the strategic management process is necessary to refine and institutionalize change. Unlike previous strategic planning attempts, the current Balanced Scorecard must be a living tool- adaptable and capable of aligning the MHS into a strategy-focused organization. This study identifies key issues that must be addressed during the communications and institutionalization processes and recommends options to reduce the gaps between the theoretical construct and the current application.

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Developing the Military Health System Balanced Scorecard: The Strategic Planning Process

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Abstract

An analysis of the MHS Strategy formulation process utilizing the Balanced Scorecard framework identifies gaps between the theoretical model and the actual steps taken. Successful implementation of the strategic plan is not a given. Many factors will influence the ultimate success or failure of senior leadership's current strategic management efforts. The Balanced Scorecard provides a framework to balance financial objectives with other equally important perspectives, overcoming the inherent overemphasis on performance measurement governing the federal sector. While the Balanced Scorecard approach provides a valid theoretical construct for strategic planning, political, financial, legal, and organizational relationships significantly impact effective implementation. Continued development of the strategic management process is necessary to refine and institutionalize change. Unlike previous strategic planning attempts, the current Balanced Scorecard must be a living tool-adaptable and capable of aligning the MHS into a strategy-focused organization. This study identifies key issues that must be addressed during the communications and institutionalization processes and recommends options to reduce the gaps between the theoretical construct and the current application.

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Introduction

The United States military health system (MHS) is one of the most complex health care organizations to be found anywhere in the world. The MHS serves 8.65 million beneficiaries, employs 91,908 military medical personnel, and 39,157 civilian employees at an annual cost of over $21.8 billion in Defense Health Program appropriations. The MHS, via the seven Uniformed Services, operates 75 military hospitals and medical centers and 461 medical clinics. The MHS also manages the TRICARE health plan under the worldwide Defense Health Program umbrella. The main healthcare delivery venue is in military health care facilities, commonly referred to as military treatment facilities (MTFs). A civilian network of providers augments the MTFs, providing care outside of MTF localities or care in specialties that the MTF cannot provide (TMA, 2002).

This study describes the MHS Strategy formulation process utilizing the Balanced Scorecard framework, identifies gaps between the actual steps and the theoretical model, and suggests options to reduce the gaps. Finally, the study identifies key issues that must be addressed during the communications, execution and institutionalization processes to insure success of MHS strategic planning. Successful implementation of the strategic plan is not a given. Many factors will influence the

ultimate success or failure of the MHS strategy formulation efforts currently under consideration by military medicine's senior leadership.

Conditions Which Prompted the Study

Macro Environmental Conditions

Establishing a strategic planning tool and implementing strategic management concepts are a significant undertakings given MHS organizational structure, size, complexity and worldwide distribution. The Department of Defense (DoD) medical infrastructure is not organized in a linear relationship, as one would assume at first glance. The usual assumption is that since the health system is part of the "military" it falls under a classic definition of a hierarchical bureaucracy when, in fact, the interrelationships are far more complicated. The specific nature of the various relationships adds additional complexity when one explores long-term strategic management.

The MHS is not immune to the pressures facing other components of the U.S. health care system. Many of the factors that impact both the direct healthcare delivery system and health plan management are present in directing and controlling the MHS. The balance between the well-known elements of the "Iron Triangle" (cost, quality, and access) is further complicated by the dual mission requirements of the MHS. In the current literature taxonomy, the MHS meets the basic definition of a network-model Health Maintenance Organization (HMO) (Longest, 2001) with its TRICARE health plan component, and is constrained by increasing costs, issues of access and quality

that are comparable to its civilian counterparts. However, the MHS deviates from the classical definition of an HMO because of dual mission requirements executed through both the direct care delivery system and the purchased care network.

The duality of the mission refers to the provision of medical support for combat operations and worldwide contingencies on the one hand, while providing comprehensive health care to all eligible beneficiaries on the other. The MHS faces a number of problems in executing strategic management objectives while trying to meet both missions in a cost-effective and efficient manner, while continuing to improve the quality of care delivered. It is sometimes difficult for an outside observer to understand the role and responsibilities of the MHS in the readiness mission, since there is no civilian equivalent in classifying a managed care organization with such divergent missions. A former Assistant Secretary of Defense for Health Affairs (ASD(HA)) reportedly referred to the MHS as "the HMO that goes to war"[1] though the current ASD(HA) considers the MHS as an integrated delivery system working towards a unified readiness mission.

The U.S. health care system is under increasing pressure to improve performance. Unfortunately, improving performance in terms of cost, quality and access often creates stresses on one element of the triangle at the expense of another. Congress,

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[1] The author cannot find a written reference to the ASD(HA)'s comment, but several MHS executives validate the statement.

health care professional organizations, regulators, consumers, and a host of other entities are increasingly vocal about the state of health care in the United States. Americans spent $1.4 trillion in health care expenditures during calendar year 2001, which equated to nearly 13% of the gross national product; an 8.6% increase over 2000 (TMA, 2002).

Over the last several years, the Institute of Medicine (IOM) produced reports that were highly critical of the U.S. health system. In a recent report, *Leadership by Example*, the IOM criticized the lack of leadership demonstrated by the federal government in improving the quality of care (IOM, 2002) for over one hundred million beneficiaries in six federal programs, including TRICARE. In the report, *To Err is Human*, the IOM stated that between 44,000 and 98,000 deaths occur annually in U.S. hospitals due to medical errors (IOM, 1999). The total cost of poor quality care, in addition to the loss of lives, is estimated to be between $17 billion and $29 billion. In a third report, *Crossing the Quality Chasm*, the IOM proposed a framework for revising the delivery of healthcare. The six dimensions of health care quality outlined in the report are safety, effectiveness, timeliness, patient-centered focus, efficiency, and equity. These six dimensions provide useful criteria to consider when exploring the strategic planning process.

Statutory and regulatory conditions

Requirements to conduct strategic planning originate from several sources, both statutory and regulatory. Policy within the executive branch also shapes the strategic management

process by prioritizing tasks and assigning explicit responsibilities to agencies and individuals. Figure 1 illustrates how requirements and inputs flow from statute through White House and DoD policy to create a strategic plan. While not a comprehensive list of sources and inputs, Figure 1 demonstrates the complexity of the strategic planning process. The outputs at the DoD, Service and MHS levels include both a Balanced Scorecard (or strategic planning equivalent) and the performance plan recognizing the linkage between the 3-5 year plan and the annual plan and subsequent performance report.

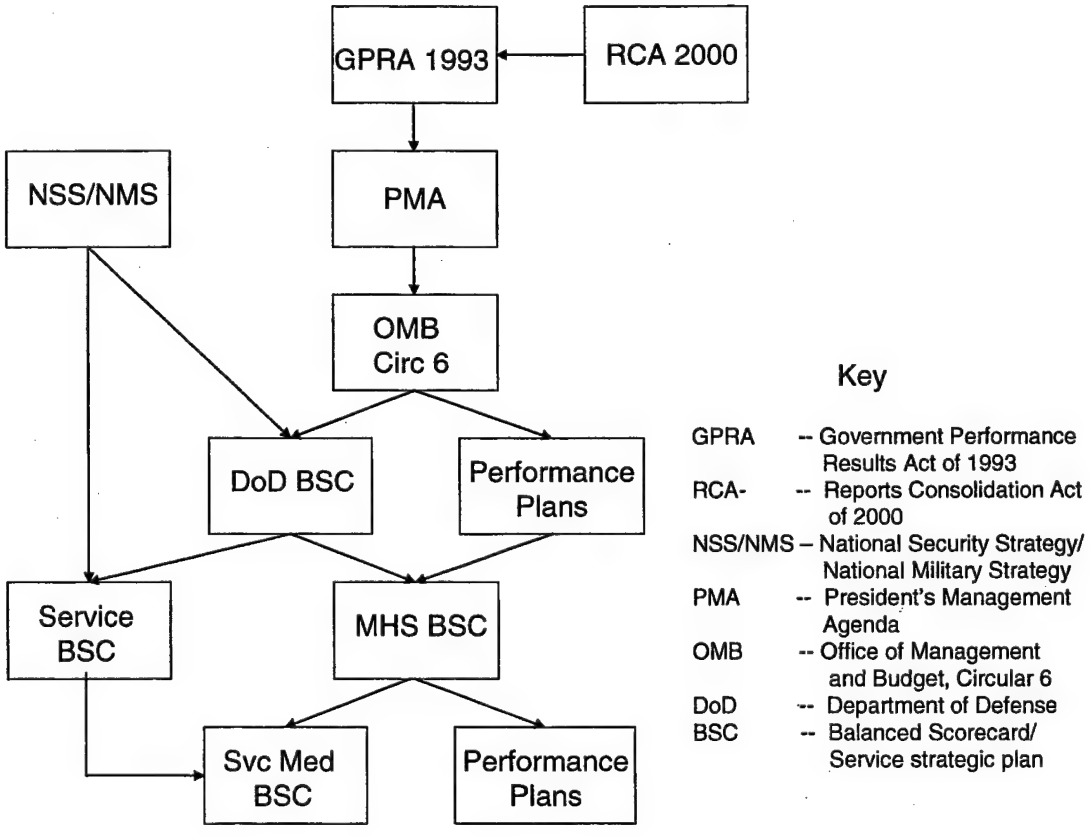

Figure 1. The flow of strategic planning requirements

The Government Performance Results Act (GPRA) of 1993 (PL 103-62) required almost every federal government agency and department to submit a strategic plan to Congress by September 30, 1997. The GPRA also requires each reporting entity to update their strategic plan every three years. The goal of GPRA is to make the federal government more efficient by focusing on results and outcomes rather than the budget. Provisions authorizing agencies to submit financial accountability reports along with program performance reports were included in the Reports Consolidation Act of 2000, amending the GPRA. The strategic plans, in six-year increments, are to align with the agency performance plans submitted in spring for the upcoming fiscal year.

At the same time, each agency must provide performance reports on how the previous fiscal year's goals were met. The approach to integrating both long-term and short-term planning requirements is monitored closely by the Government Accounting Office (GAO) for Congress while the Office for Management and Budget (OMB) serves in this role as executive agent for the White House (OMB, 2002). The emphasis is on fiscal accountability and performance measurement and loosely concerns itself with process improvement and goal integration.

The President's Management Agenda (PMA) and guidance from within the Department of Defense provide integrative and iterative requirements for strategic planning. The PMA outlines five government-wide initiatives. Under the goal of budget and performance integration, the administration places additional

emphasis on appropriate resource allocation to agencies with measurable performance measures. The PMA states, "after eight years of experience (since GPRA), progress towards the use of performance information has been discouraging." (OMB, 2002, p. 27). One PMA goal in Fiscal Year (FY) 2003 is to focus on performance measurement and integrate performance review of budget decisions (OMB, 2002). An additional requirement from the PMA that directly impacts the MHS is the program initiative to coordinate DoD and VA programs and systems by implementing the recommendations of the *Presidential Task Force (PTF) to Improve Health Care to Veterans.*

Within DoD, the Secretary of Defense defined specific guidance referencing transparency between the budget process and performance measurement. The guidance stated in the report, *2002 Year in Review*, is very specific. "The Department of Defense must have a strategy-driven budget -- not a budget-driven strategy." (OSD, 2002, P. 11). Also, the department established a new framework to delineate a new approach to managing different kinds of defense risk. The four areas are force management risk, operational risk, future challenges risk and institutional risk. All four must be considered in balance. Failure to address any one of the sources of risk could affect the ability of the United States to achieve its defense strategy goals. Two of the four, force management risk and institutional risk, have specific implications for the military health system. The specified tasks within the framework provide clearly defined objectives for planning purposes.

Each department's annual performance plans, as required by GPRA, also provide guidance to each subordinate agency and program and include specific performance measurement targets for the upcoming fiscal year. For the Defense Health Program (DHP), the Undersecretary of Defense for Personnel and Readiness (USD(P&R)) and the Assistant Secretary of Defense for Health Affairs ratified a common set of performance measures by which Health Affairs will be evaluated each fiscal year. The performance plan, or performance contract (these terms are often used interchangeably), plays a significant role in the relationship between the five main elements of the military health system: The Office of the Assistant Secretary of Defense for Health Affairs, defines policy and oversees the execution of the DHP; the three Uniformed Services (Army, Navy, and Air Force), operate the MTFs; and the TRICARE Management Activity (TMA), DoD's Field Activity responsible for the management of the TRICARE program.

Organizational and Structural Conditions

The DoD organizational structure plays a pivotal role in any discussion of strategic management. The Department of Defense is comprised of the three Services, the Office of the Secretary of Defense, the Joint Chiefs of Staff, and the Unified Combatant Commands. As illustrated in Figure 2, the three Service departments report to the Secretary and the Under Secretary of Defense, as do the Unified Combatant Commands and the Chairman of the Joint Chiefs of Staff. Under the Office of the Secretary of Defense (OSD) umbrella are all of the Under

Secretaries and Assistant Secretaries. DoD Field Activities and Defense Agencies report to OSD.

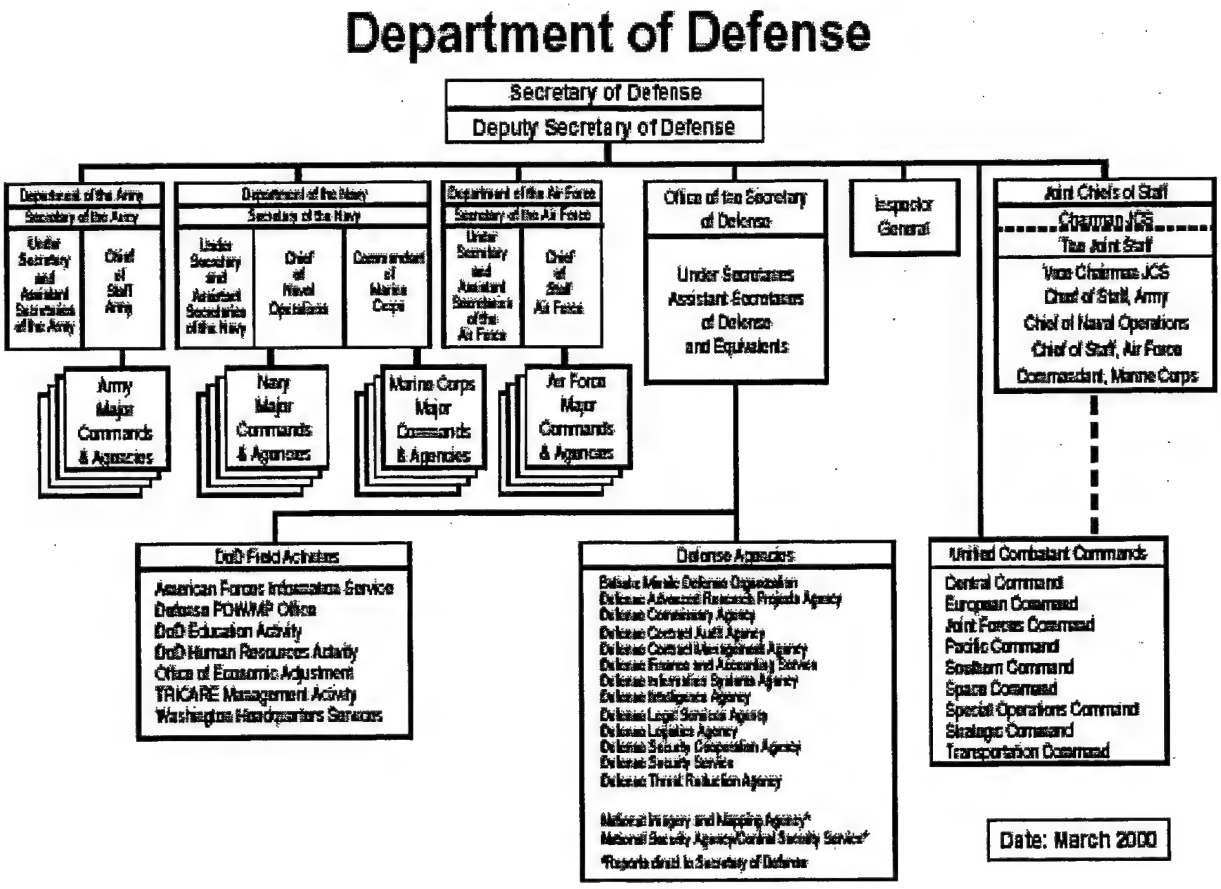

Figure 2. Organizational Chart for the Department of Defense

The ASD(HA) does not exert direct line authority over any of the Services or Service component agencies, but does exercise direct authority over TMA as outlined by Department of Defense Directive (DoDD). The DoDD delegates authority from the Secretary of Defense through the USD(P&R)to the ASD(HA) to

accomplish three missions: manage TRICARE, manage and execute the DHP appropriation and the DoD Unified Medical Program, and support the Uniformed Services in implementation of the TRICARE program and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The DoDD establishes TMA as a DoD Field Activity subordinate to the USD(P&R) under the direction, authority and control of the ASD(HA) (DoDD 5136.12).

The three Surgeons General report directly to their respective Service Chiefs. In addition, they also have an indirect reporting relationship with the ASD(HA) and TMA as the operational field activity for the MHS relative to financial accountability and performance under the DHP and execution of health policy. However, the reporting relationship between the three Service Surgeon's General and the ASD(HA) is difficult to analyze and even more difficult to anticipate. Usually, the relationship between these four individuals is shaped by the personalities involved, the underlying bureaucratic mindset of their respective staffs, and the level of oversight and scrutiny provided by the Service's line community, the administration and Congress. The relationships, both direct and indirect, are indicated in Figure 3 and increase the complexity of decision-making and policy execution across the MHS. Therefore, one cannot characterize the MHS as a true hierarchical bureaucracy, but one that is complex and adaptive to changes in the environment.

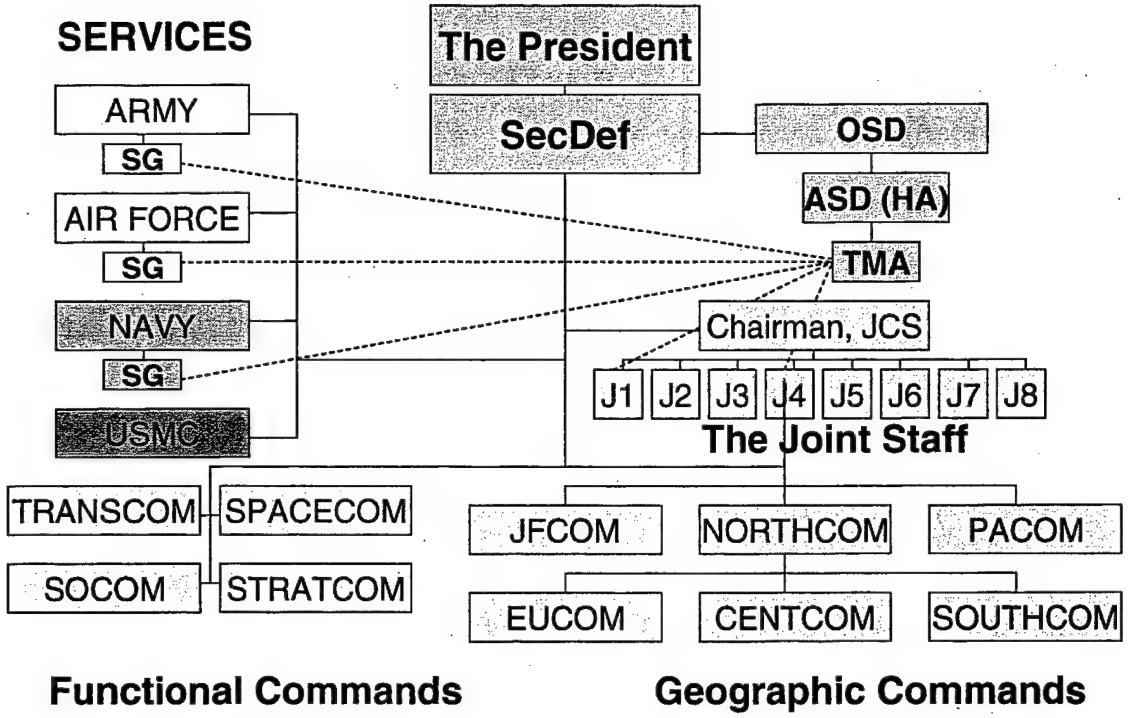

Figure 3. Lines of Communication and Authority within the MHS

In July 2002, the ASD(HA) directed a reorganization of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) and TMA. The most significant change in organizational structure occurred in the realignment of Regional Operations. Under the Next Generation of TRICARE Contracts (T-Nex) proposal, three regions are formed reporting to the Director of Regional Operations (DRO) (dual-hatted as the TMA Program Executive Officer). The DRO reports to the TMA Chief Operating Officer who is also dual-hatted as indicated in Figure 4. The reorganization plays an important part in the strategy planning process.

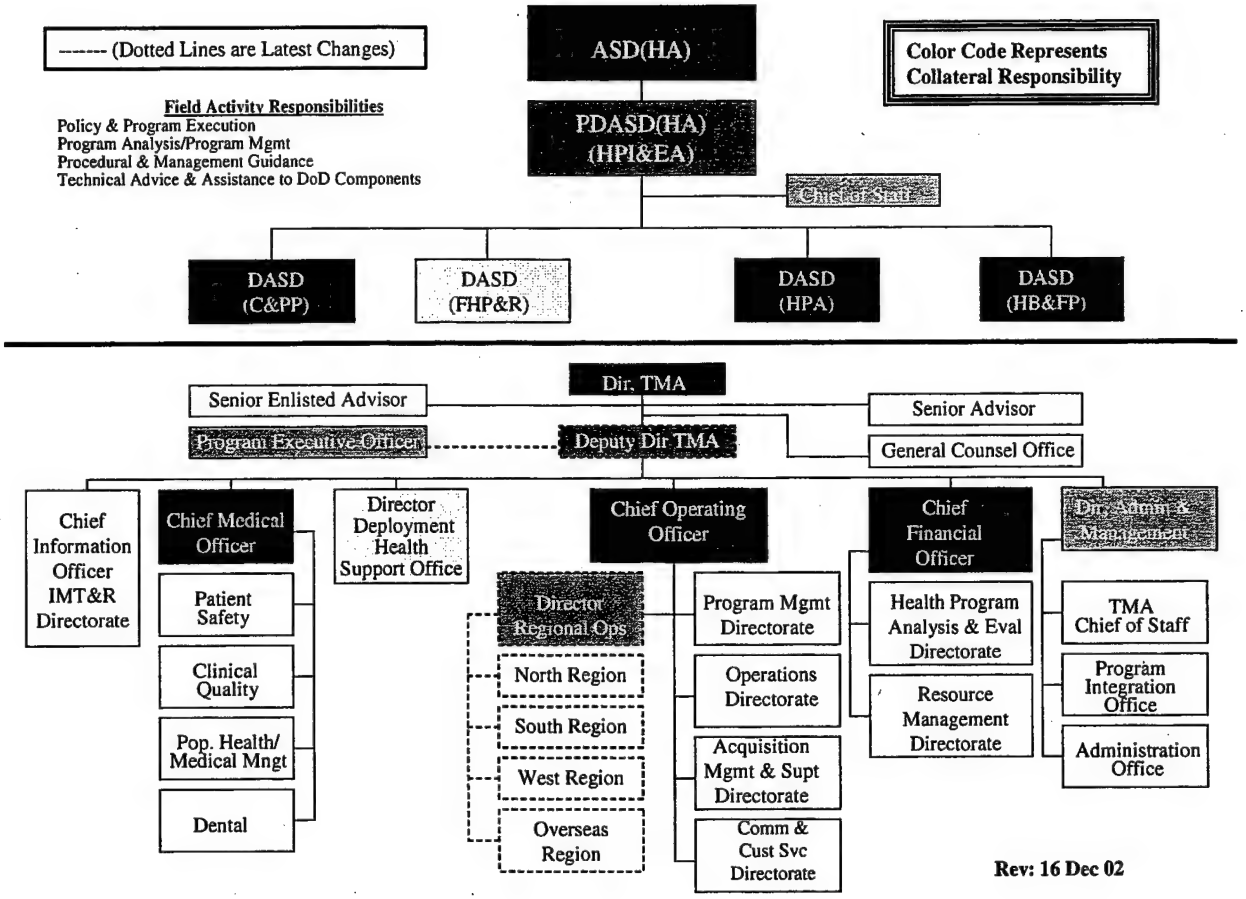

Figure 4. OASD(HA)/TMA Organizational Chart

The ASD(HA) also realigned the policy activities of the OASD(HA) with the execution responsibilities delegated to TMA as the DoD Field Activity. The reorganization created a fourth Deputy Assistant Secretary of Defense (DASD), the DASD for Health Plan Administration and integrated the other three DASDs into the operational elements of TMA. Thus, in the current organizational structure, the policy and execution of programs are intertwined, creating a matrix organization at both policy and program execution levels. Figure 4 indicates the revised

structure with a line delineating the policy role from the execution role.

Statement of the Problem

In general, previous efforts at formal strategic planning and implementing measurable change management in the MHS have met with limited success. Although there have been requirements for a formal strategic plan since 1993, from 1998 until 2002, the function of formal, deliberate strategic planning activity significantly decreased. Strategy formulation moved from a deliberate planning model to what Mintzberg (1985) calls an "emergent" strategy, realized strategies that were never intended but occurred in incremental fashion in the course of daily business. Although there were minimal efforts at deliberate, formal planning, Health Affairs began a pattern of actions that presumed an organizational intent to concentrate on short-term actions, focusing on executing program decisions driven by the Planning, Programming, and Budgeting System (PPBS)[2].

During the fall of 2002, after the current strategic planning process was well under way, a number of document binders were found in one of the Health Affairs offices. These meticulously labeled binders contained all of the previous strategic planning documents, including detailed notes of the

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[2]The six-year federal budget process that drives all federal expenditures.

participants, from 1993 through 1998. After 1998, the formal strategic planning process lapsed and became a lower priority as program requirements and expansion of the TRICARE benefit took a more prominent role in the short-term planning cycle. As in many organizations, strategic planning had greater or lesser significance at some points than at others. After all, everyone had a copy of the strategic plan sitting on his or her shelf. And, until resurrected in the summer of 2002, few seemed to notice there was no longer a formal strategic, integrated plan for the future. Most management efforts focused on implementing current business requirements. Programs continued, policies were developed, appropriations were duly budgeted and executed, performance plans (with annual, short-range goals) were established, and fiscal accountability reports were submitted.

Ultimately, during the formal strategic planning hiatus, the MTFs and the provider network still treated patients; health care benefits expanded, granting additional entitlements to eligible beneficiaries; and demonstration projects filled some of the gaps in the TRICARE program. However, a lack of cohesiveness in managing the health plan and limited prioritization of performance goals created friction between OASD(HA)/TMA and the Services, generated annual performance plans with unsuitable measures, and raised some concern over the stewardship of resources given to the MHS in the DHP appropriations.

The fundamental management questions thus become: What processes are required for the MHS to meet its fiduciary responsibility of providing health care to all eligible beneficiaries; how does the MHS meet both its readiness mission while providing care in peacetime; and how does the MHS succeed in managing a multi-layered health care organization in the twenty-first century? In today's environment, there are multiple stakeholders with competing interests, diminishing resources, and persistent calls to simultaneously increase access, lower costs, and improve the quality of care.

Literature Review

Defining Strategy, Strategic Planning and Strategic Management

Most management textbooks define strategy in similar terms, following the scientific management school outline where strategy follows a logical, deliberate course. Chandler's definition of strategy as "basic long term goals and objectives of an enterprise, and the adoption of courses of action and the allocation of resources necessary for carrying out these goals" (Mintzberg, 1978, p. 935) is typical of this descriptive form. Longest, et al, uses a similar definition of strategy as a way of accomplishing organizational objectives (Longest & Rakich, 2000). From a different perspective, Mintzberg defines strategy as "a pattern in a stream of decisions" (Mintzberg, 1978, p. 935). Ginter, et al, mirrors this philosophy, viewing strategy "as the behavior of the organization … and addresses three questions: what the organization should do, can do, and wants to do" (Ginter, et al, 1998, p.10).

Although the statutory and regulatory requirements specify development of a strategic plan (ways), strategic planning is a process (means) for an organization to reach a desired future (ends). Ginter, et al, (1998, p. 13) also describes strategic planning as "the organizational process for identifying the desired future and developing decision guidelines for getting there." Longest, et al (2001, p. 348), defines planning as "anticipating the future, assessing present conditions, and making decisions concerning organizational direction, programs and resource deployment." Both definitions follow general systems theory as first described by the experiments of Frederick Taylor, representing a linear approach to problem solving and espoused by Alfred Marshall's theory of industrial organization.

Ginter, Rucks, and Duncan (1985) describe the linear or sequential approach to strategic management as elements of normative models. The authors cite research by Wheelen and Hunger reflecting that normative or prescriptive models "generally reflect an explicit, planned and rational approach" (Ginter, et al, 1985, P. 581). The authors' own research indicates that while the normative models tend to follow a sequential path in a mechanistic approach, practitioners of strategic planning prefer this approach.

Some researchers believe that normative models do not reflect the complexities and difficulties of current strategic management practices. As stated earlier, Mintzberg (1978) describes some strategy as unintended, as opposed to a strategy

defined by a planned approach. Lindblom (1979) illustrates the incremental nature of most strategy and policy development. Ginter, et al (1985) relates Fahey's research that strategy is often political in nature. Schuler, et al., also study the role of politics as a strategic means to improve competitive advantage (Schuler, et al, 2002). All three views differ from Ginter, Rucks and Duncan's conclusion that normative models provide planners with an appropriate framework, even though the sequential relationship between the phases has not been proven (Ginter, et al, 1985, p. 583).

Strategic planning is not synonymous with strategic management. Planning is certainly part of the management process, but as a discipline, strategic management has evolved to include strategic implementation and a control process. Strategic management also differs from health policy planning since the focus of strategic management is organization specific while health policy has a broader context (Ginter, et al, 1998).

Other definitions of strategic management exist. Longest and Rakich extend the logic of the strategic planning process by describing strategic management as "a systematic process that focuses on influencing the external environment so that it is more favorable to the organization" (Longest & Rakich, 2000, p. 384). Pankratz (1991) describes strategic alignment as an essential element of the strategic management process. He states, "Managing the organization toward functional fit and strategic fit is strategic management" (Pankratz, 1991, p. 66). Therefore, strategic management combines planning, executing and

controlling processes to meet a desired future endstate.

Strategic Planning Theory

Kongstvedt (2001) points out that the complexity of various aspects of a health system makes describing it extremely difficult, especially given there are any number of variables to consider. In essence, health care systems could be classified as nonlinear, although researchers model the interrelationships between any numbers of variables. Yet, theorists apply a linear approach to much of our strategic thinking and strategic management philosophy. For decision-makers and managers responsible for execution of strategy, overlaying a logical and linear approach to the process overcomes some of the problems resulting from the complexity of describing the relationships between many moving parts.

The reliance on linear thinking at the macro-level often masks some of the more complex relationships at the micro-level. The theory of complex adaptive systems applies quantum mechanics at the micro-level to describe non-linear relationships between agents. Pascale (1999) reflects that many systems are complex but not adaptive, since they fail to meet some or all of the four tests for a complex adaptive system. Complexity theory, as it is often called, describes some agents as chaotic and disorderly, while other agents are orderly and consistent. Several researchers apply complexity theory to describe the relationships that exist within the health care delivery system (Dershin, 1999; Rouse, 2000; Plsek & Wilson, 2001; Burns, 2001; Kernick, 2002).

Roberts (2000) discusses adherence to a normative planning model as the basis for GPRA. Her research describes a synoptic approach embodied by the GRPA. The GPRA has considerable Congressional support from both political parties, the Government Accounting Office (GAO), and other oversight groups that watchdog the executive branch of the federal government. She describes the synoptic approach as "integrated comprehensiveness" whereby executives integrate all significant management decisions into the organization's overall strategy. As an extension of the rational goal model, the linkage between planning, execution and managerial control improves.

However, since the GRPA drives the strategic planning processes within the executive branch, it raises pointed questions about the efficacy of strategic planning predicated solely on performance measurement and prescriptive oversight. Roberts describes the three fallacies, articulated by Mintzberg, that make the synoptic approach problematic, especially for dynamic and non-hierarchical government agencies but she does go on to illustrate that this approach fits one organizational type, namely the machine bureaucracy (hierarchical bureaucracy) (Roberts, 2000). Roberts' concern about the synoptic approach "one size fits all" strategic planning model is valid, especially in government agencies, "particularly those in highly politicized contexts, with diverse missions, conflicting stakeholder interests, and cross-cutting programs that require collaboration among multiple bureaus and levels of government" (Roberts, 2000, p. 298).

Mintzberg offers a different interpretation of the role of strategic planning. He believes that strategic planning is not strategic thinking since strategic planning is really analysis while strategic thinking is about synthesis. Mintberg makes a clear distinction between the planning and execution and accuses planners as incapable of providing synthesis to strategic plans. His firm belief is that strategic management fails when managers only consider one "planning" point of view, and organizational planners promote planning as a way to limit the manager's role in strategic decision-making. He further states that "planning's failure to transcend the categories explains why it has discouraged serious organizational change" (Mintzberg, 1994, p. 109).

Mintzberg describes the ten different schools of thought regarding strategic planning and in terms of prescriptive (or "aught") and descriptive (or "is"), though some current research indicates some blending of the strategy formation schools (Mintzberg & Lampel, 1999). His article, *Reflecting on the Strategy Process* (Sloan Management Review, Spring, 1999), outlines the ten schools, but also asks a pointed question: Do they represent different approaches to strategy formulation or are they different parts of the same process? While purposely not providing an answer to that question, it poses an intriguing question on what school of thought to consider when evaluating various planning models. Clearly, the answer lies with a planning model that fits organizational needs based on its culture, values and stakeholder expectations.

Strategic Planning Models

Various planning models have been used in the last thirty years. Some models have had more success than others, with other models building upon the success or failure of previous efforts. In all cases, the model itself is not the issue; it is the journey through the process that counts. Regardless of whether a model is based on a rational-goal theory, incorporates continuous quality control features or looks for the differences in random patterns of behavior advocated in Chaos theory, the most important thing to remember is that there are no shortcuts. Strategic management is fairly easy to plan but often difficult to execute.

In theory, one of the simplest planning models incorporates Deming and Juran's quality management philosophy into a process called Hoshin Planning. Since Hoshin Kanri, also known as Management by Planning and Management by Policy are well established systems in quality control management, the Japanese have demonstrated great success in adopting this planning process at the strategic level. Following the Shewhart Cycle of Plan-Do-Check-Act, Hoshin Planning "describe(s) the evolution of achievable objectives and plans that flow from any organization's long term vision" (Goal/QPC Research Committee, 1989, p. 5), once the organization has developed an understanding of the external environment and where the organization fits into that environment. The Hoshin Planning process results in a 3-5 year plan "based on an analysis of the broad areas from improvement that will block attainment of the

vision" (Goal/QPC Research Committee, 1989, p. 5).

Most planning models follow a general model based on normative guidelines. Ginter, Rucks and Duncan (1985) describe the general model as a continuous process involving eight steps as indicated in Figure 5.

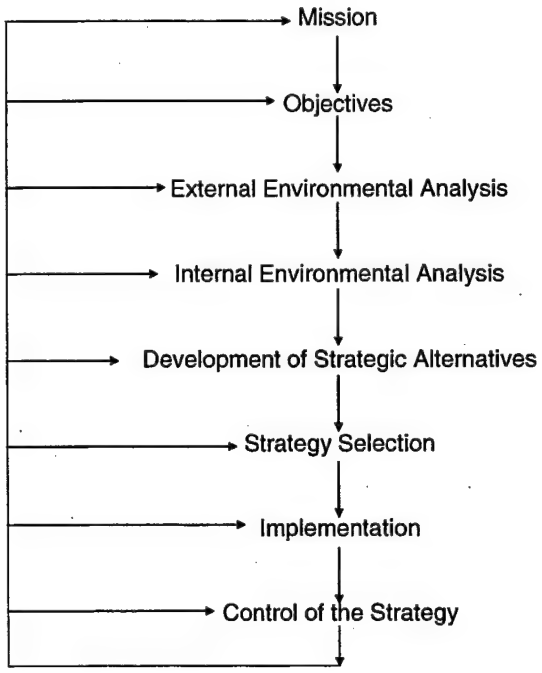

Figure 5. Normative Steps in Strategic Planning

While there is no conclusive evidence that sequential relationships between the steps exist, it does provide a means of simplifying a complex set of events and information flow. One important note stated by the authors is that "the intent…is not to imply that a component must be completed before the next phase is initiated…however, sequences should not be dismissed as unimportant" (Ginter, et al, 1985, p. 583).

In later research, Ginter, Swayne and Duncan (1998) combine the steps into four broader processes with some rearranging of the steps in figure 5: situational analysis, strategy formulation, strategic implementation and strategic control. Situational analysis includes both internal and external analysis and establishing or validating the organizational mission and vision. Strategy formulation includes setting objective goals and developing strategic alternatives. Strategy implementation drives the organization through the strategy selection process and actual implementation. The final process, strategy control, remains the same. The four processes provide a systematic approach to strategic planning.

David Norton and Robert Kaplan initially developed the Balanced Scorecard (BSC) as an integrative approach to performance measurement. The balanced scorecard provides a holistic view of the organization by linking other value-based processes to translate an organization's mission and vision into strategically aligned actions. Kaplan and Norton state, "the balanced scorecard retains financial measurement as a critical summary of business performance, but it also highlights a more general, integrated set of measurements that link customers, internal processes, employee and systems to long-term financial success" (Kaplan & Norton, 1996, p. 54). These four perspectives, financial, internal business process, customer, and learning and growth are integrated to improve performance, though the system has become much more than a performance measurement system.

Since its inception in 1992, the balanced scorecard has evolved into a strategic management system. As Voelker, et al states, "the BSC is a system that can align all operational activities with overall organization strategy" (Voelker, et al, 2001, p. 14). The BSC framework applies five core principles: translate the strategy into operational terms; align the organization to the strategy; make strategy everyone's job; make strategy a continual process; and mobilize change through executive leadership (Inamdar, 2002, p. 181). The BSC has its basis in other normative-based models but also incorporates Total Quality Management/Continuous Quality Improvement (TQM/CQI) and Hoshin Planning concepts by its reflection on continuous improvement and balance between perspectives.

Performance measurement is still the underpinning of the BSC approach. Just as the financial perspective is not the only viewpoint of organizational success, Kaplan and Norton also illustrate that "no single measure can provide a clear performance target or focus attention on the critical areas of the business" (Kaplan & Norton, 1992, p. 71). By the same token, "what you measure is what you get" (Kaplan & Norton, 1992, p. 71), recognizing that managers and employees adjust their behavior based on an organization's measurement system. While management always has been responsive to financial measures, the organization improves when the other, non-financial measures are integrated. As Kaplan and Norton point out, "effective management must be an integral part of the management process" (Kaplan & Norton, 1993, p. 134).

Purpose

The purpose of this retrospective study is to describe the MHS Strategic Planning process developed using Kaplan and Norton's Balanced Scorecard approach during the strategic formulation process. This study proposes to (a) match the MHS strategy formulation process to the BSC, (b) identify any gap between the actual process and the theory, and (c) provide suggestions to reduce the gap. In addition, the study will identify key issues that must be addressed to insure success of the BSC planning process and the other subsequent processes within the MHS strategic management framework. The preferred endstate is a strategic management process that is capable of meeting the fundamental management questions identified earlier.

Methods and Procedures

MHS Strategic Management Framework

The MHS strategic management framework is illustrated in Figure 6. The conceptual map is designed to outline the four processes of the BSC methodology leading to a strategy-focused organization. The first process of the framework is to formulate strategic planning and translate the strategy into operational terms. The second process is to communicate the strategy, both vertically and horizontally, increasing strategic awareness throughout the organization. Also, the process should align the organization to the strategy by integrating business and financial plans of all associated business units (in this case the Services and HA/TMA). The third process is to execute

the strategy, using annual performance plans as short-term business planning tools. The fourth process is to make strategic planning a continuous process through appropriate feedback and organizational learning.

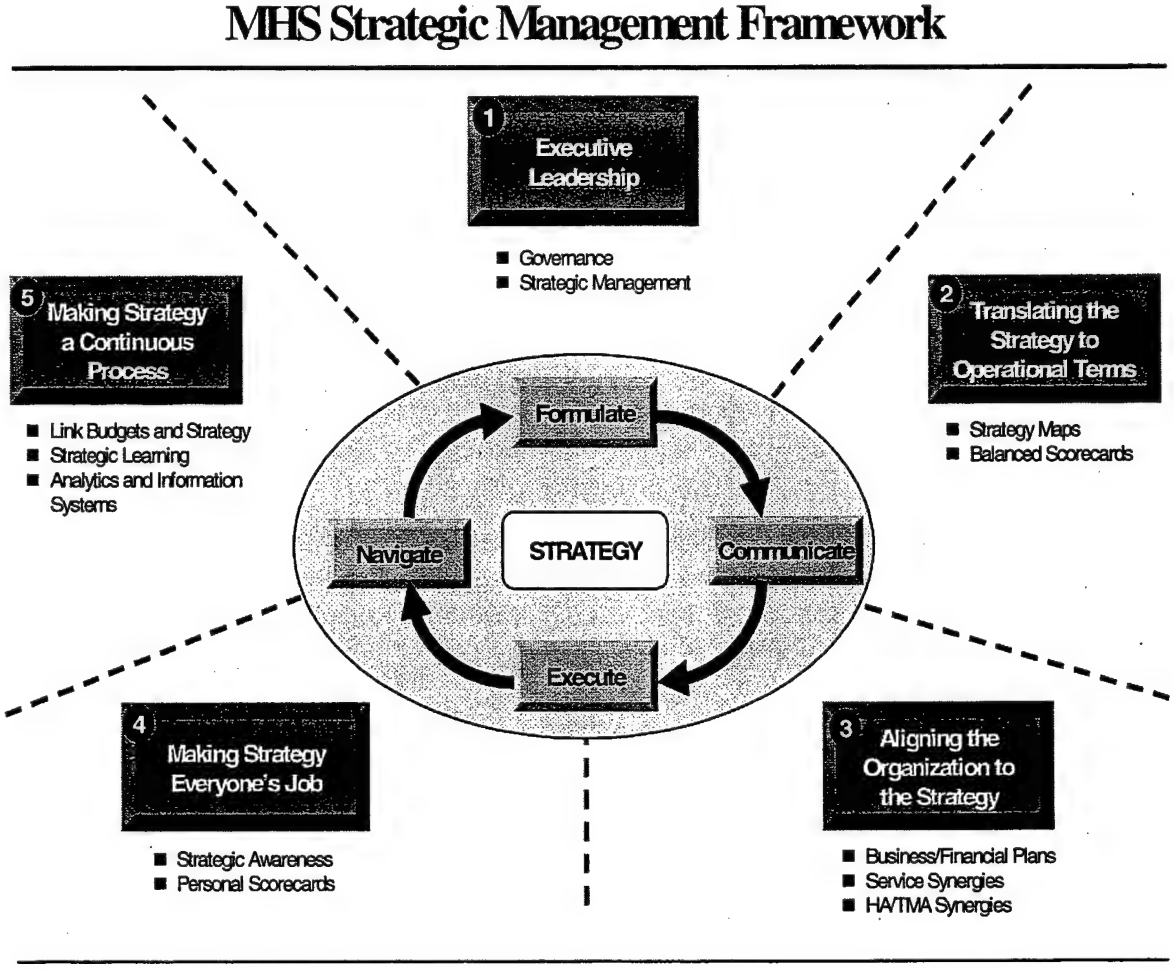

Figure 6. MHS Strategic Management Framework

The framework described in Figure 6 is a continuous process, following Total Quality Improvement and Continuous Quality Improvement methodologies. The framework provides long-term vision of how strategic management will be conducted in the future. This study concentrates on the planning process necessary to formulate the strategy and begin implementation. Formulating strategy, however, is only one component of the strategic management process. A successful strategic plan must bridge formulating the strategy with implementation and reworking the product. The strategic plan must be a living, working document; otherwise it becomes an instant anachronism, better left on the shelf.

MHS Strategic Planning Process

The strategic planning conceptual map considers current literature on the strategy formulation process discussed by Ginter, et al (1998), and Longest (2001). Ginter's four phases of strategic management provide an excellent framework to develop a strategic planning process that allows for the differences between a public, health management organization and a for-profit business model. Because of the uniqueness of the MHS, Longest's five-phase model, although similar to Ginter's, is less easily adaptable to the MHS planning process since it draws heavily from a business model.

The MHS conceptual map (Figure 7) provides a basis for measuring performance and is based on the work of Donabedian (1980), which links structure, process, and outcome in a quality assessment and systems monitoring model. Figure 7 illustrates a

simplified Donabedian model with the flowchart outlining the structure, Ginter, et al's four planning phases as the process, and the planning outputs as system outcomes.

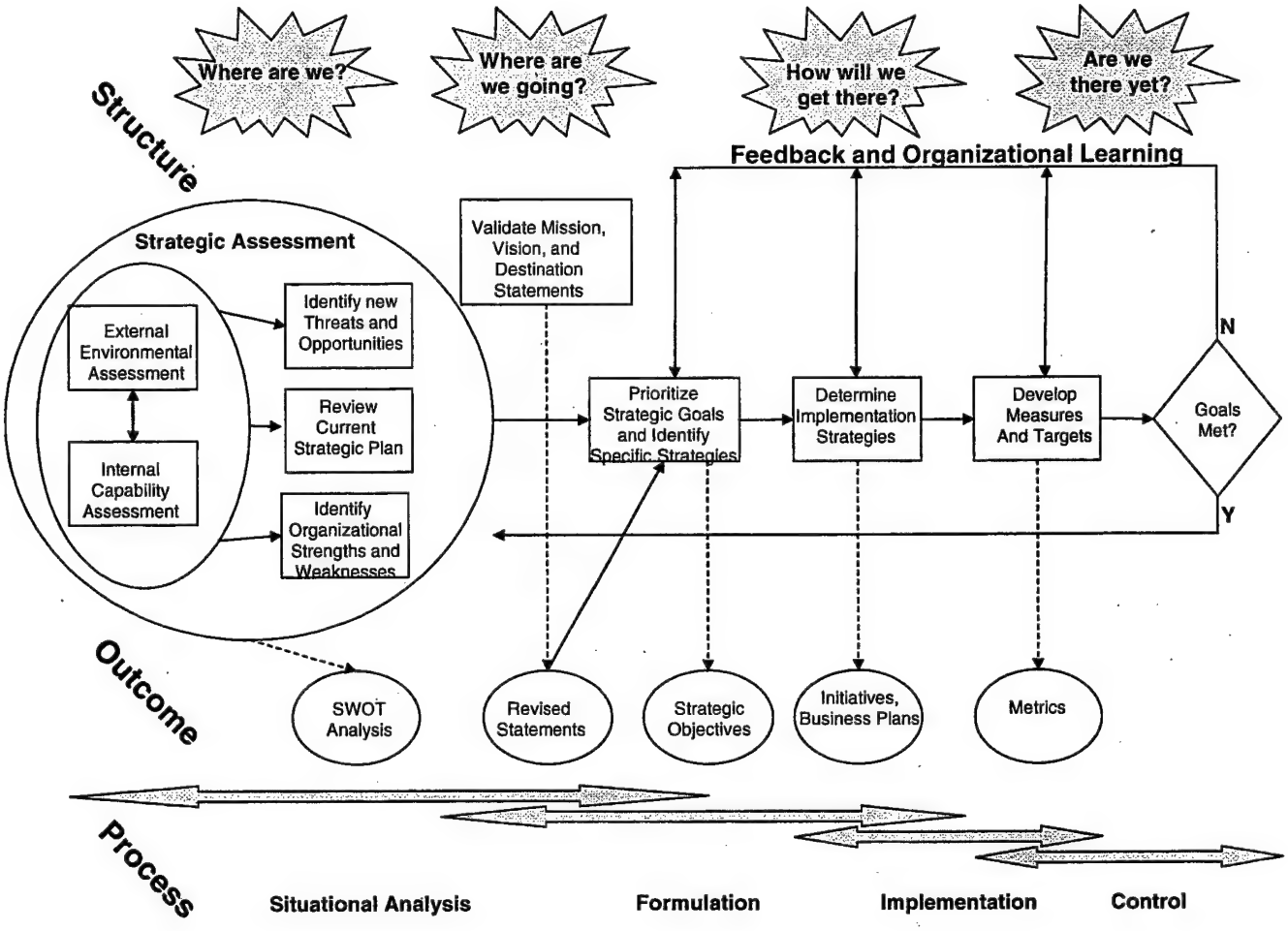

Figure 7. MHS Strategic Planning Conceptual Map

The situational analysis assessment process incorporates the traditional environmental analysis consistent with the literature. The external environmental assessment should identify new threats and potential opportunities, while an

internal review of organizational capabilities should identify strengths and weaknesses. The assessment also considers a review of current strategic planning or performance measurement systems. Reviewing and validating the current mission, vision statements, and describing the endstate or destination, yields several outputs: a Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis and revised mission, vision, and destination statements. The situational analysis is complete when the question "where are we" is answered.

Based on the situational analysis, strategy formulation answers the question of "where are we going." The revised mission and vision begin the discussion of identifying and prioritizing strategic goals. In Ginter, et al's model, formulation begins with identifying directional strategies. For the MHS, with its congressionally-mandated programs and defined beneficiary populations, the traditional approach to directional strategy does not apply. However, the MHS leadership can apply strategic thinking towards prioritizing strategic goals and long-term objectives, considering specific strategies to reach a preferred endstate.

Likewise, traditional business model strategic planning processes link the directional strategy with positional, competitive or market-entry implementation strategies in strategy execution. In the MHS, implementation strategies are usually confined to positioning strategies. Implementation strategies, however, do draw upon other underlying strategies to be successful. Marketing, information technology systems, human

resources, and budgetary strategies support how the strategic objectives will be met. The question of "how we will get there" is answered during this process with specific initiatives, annual performance or business plans, integrating the four business process strategies.

The strategic control process answers the question of "are we there yet?" The MHS is proficient at developing metrics and performance management systems, but linking appropriate measurements and targets to specific objectives is much more difficult. Used properly, the BSC method should provide a combination of leading indicators that drive performance, with lagging indicators that utilize historical data and extrapolate future trends.

The conceptual map also draws upon Argyris' (1976) double-loop learning theory by establishing feedback at every phase to reconsider the underlying assumptions made before moving on to the next step. The danger is that the process fails to progress to the next step or does so in such a way as to lose focus. However, the value of creating a strategy-focused organization is worth the risk. The real risk lies with not questioning the underlying assumptions or assuming that past facts are indicative of future results.

If strategic goals are met, the process begins again with updating the strategic assessment. If strategic goals are not met, returning to the goal development, implementation and performance measurement steps may provide insight into reasons for failing to attain the desired endstate.

Methodology

The strategic plan development process conducted by the MHS leadership was built on the requirement to produce a strategic plan by September 30, 2002. The target date was moved back to late November when it became quickly apparent that the initial target date could not be met. The leadership decided on facilitated planning meetings utilizing a commercial vendor with experience working with the Army Medical Department (AMEDD) on the AMEDD Balanced Scorecard. Balanced Scorecard Collaborative, Incorporated, was chosen as the vendor and facilitated planning sessions beginning in July and extending through late November.

The leadership met in four, four-hour planning sessions over the 16-week period, providing periodic validation of the process and approving the outputs at each step. A group of deputies met more frequently and provided actual analysis and rough drafts of all documents and outputs. The November 25, 2002 meeting of the leadership was designated as the approval date of the strategic plan. The 16-week development process was shorter than recommended by the vendor. Some of the intervening work that normally occurs would have extended the process to almost six months.

The formulation process was a four-phase approach utilizing the balanced scorecard methodology in the context of the conceptual map in Figure 7. Each phase was sequential and followed the established training program outlined by the vendor in the first meeting. The vendor described the process and the MHS leadership agreed to the proposal.

Phase I: Training the Executive Leadership

During the first phase, the facilitators conducted training for the MHS Leadership, orienting members to the balanced scorecard methodology and the planning process. The BSC requires some training and refinement in order to fit into a non-standard business model that the MHS represents. The Leadership Team received an overview of the balanced scorecard methodology and reviewed how the mission, vision and destination are linked together. Appendix A, Tab A contains the training package for the Leadership Team. The Core Team received additional training (Appendix A, Tab B) that the vendor utilized for a more in depth orientation to the Balanced Scorecard and strategy formulation process.

Phase II: Personal Interviews

During the second phase, the vendor conducted personal interviews with each member of the Leadership Team (Appendix B, Tab A contains the interview worksheet template) to solicit their opinions on the following issues:

- Future endstate, or destination of the planning process
- Key stakeholders and stakeholder requirements
- Delineation of customer and financial goals
- Perspective on current internal processes
- Role of learning and growth as enablers.

Phase III: Translating the Strategy into Operational Terms

The third phase was the strategy formulation stage where the MHS leadership began the process of translating the vision into operational terms. To accomplish this, the MHS leadership

was organized into two groups: The Leadership Team and the Core Team. The objective during this phase was to translate the vision into the following outputs:

- Mission, Vision and Destination
- MHS Strategy Architecture
- MHS Strategy Map
- Measurement Worksheets
- Initiative Worksheets

The Leadership Team is comprised of the ASD(HA), the six senior members of the HA staff, the Chief Information Officer (CIO), TMA Program Executive Officer (PEO), the three Service Surgeons General, a senior executive from the Office of the Assistant Secretary of Defense for Reserve Affairs (OASD(RA), and a representative from the Joint Staff (J-4 Medical). The role of the Leadership Team is to provide senior level executive leadership for the planning process and continue to monitor strategic management efforts as outlined in the conceptual map (Figure 7). The ASD(HA) chairs the team.

The Core Team is comprised of the three Service Deputy Surgeons General, the Chief Information Officer, the Program Executive Officer, and several senior staff officers from the Services and Health Affairs, and is chaired by the TMA Program Executive Officer. It should be noted that both the PEO and CIO are also members of the Leadership Team, providing a liaison and continuity between the two groups. The Core Team provided the day-to-day development of the planning documents and developed drafts for review by the Leadership Team.

The Balanced Scorecard was designed using the following steps:

- Conduct environmental assessment to identify customers, stakeholders, and endstate.
- Review the Mission, Vision and Destination.
- Design the MHS Strategy architecture using the four BSC perspectives as a model, and assign theme sponsors.
- Identify strategic objectives and outline objective statements.
- Identify appropriate performance drivers to measure success, and operationally define the measures.
- Identify the appropriate stretch targets over the six year period of the plan.
- Identify initiatives that produce measurable change.
- Produce the outputs as indicated in the conceptual map (Figure 7).

Phase IV: Aligning the Strategy

Once the MHS Balanced Scorecard is designed, the fourth phase will be alignment of the organization to the strategy and communication of the strategy to stakeholders, customers, subordinate organizations and the public at large. The alignment process will include the following steps:

- Alignment of existing measurement reporting systems to the BSC metrics
- Cross-walk of the three Service strategic planning documents to the MHS BSC
- Cross-walk of the Health Affairs performance plans to the

MHS BSC

- Outline the communications strategy for the MHS BSC

For purposes of this study, the third phase will include a gap analysis, as stated in the purpose and covered in detail in the discussion section. Recommendations based on the gap analysis will be discussed in the recommendations and conclusion section. The discussion section also will include identification of key problem areas in the execution of the strategy for future consideration.

Results

The results of the strategic planning process are not surprising given the emphasis placed on generating a working plan within a short timeframe. Building a strategic management document to support significant change in a bureaucratic organization requires time and energy. Certainly, the principals in the leadership and core teams devoted significant time to the process, yet the end result of creating real, measurable and permanent change remains to be seen. The original target date of September 30, 2002 was not realistic given the magnitude of the task and only 16 weeks to formulate the plan and begin the task of creating new management paradigms.

The utilization of the Balanced Scorecard Collaborative as a facilitator to the process was useful in several ways to include bringing an outside perspective and experience with the balanced scorecard methodology to the planning process. However, as with many outside consultants in the strategic

management field, the goal of the vendor is to meet its contractual requirements and position itself for future business. That said, the vendor worked with the unique problems presented by the military health system and the Leadership Team, moving the process through the preliminary situational analysis process and into strategy formulation and measurement as required by their stated methodology and contract requirements. Over the succeeding four months, the vendor organized the activities of the Leadership Team, conducted the initial interviews, provided the executive level training on the balanced scorecard approach, and facilitated the four, four-hour executive leadership team sessions to review and validate the process.

The strategy formulation process, conducted in the four phases outlined in the methodology, began with training to the Leadership Team on the Balanced Scorecard methodology. Since the AMEDD had been utilizing the BSC for almost two years at this point, the Army Surgeon General provided lessons learned and additional insight into the development and management process. The Leadership Team training was completed in one session, with a separate training session conducted for the Core Team.

The second phase consisted of interviews with each member of the Leadership Team on the issues identified in the methodology. Unfortunately, the interview summaries are not complete with some questions not answered by all respondents. Since the interviews were a surrogate for a formal situational

analysis, a SWOT analysis was not developed from the interview results. The responses in the interview summaries (Tab B of Appendix B) are fairly consistent, especially those responses provided by the uniformed Services members.

The Core Team and Leadership Team spent several weeks defining and validating the MHS mission, vision and destination statements. The mission statement was not radically changed from the previous version, with the revised statement emphasizing readiness as the primary role of the MHS. The vision statement was a new adaptation, recognizing a broader definition of health, not one solely based on disease management. The challenge became creating a destination statement that quantifies success. Ultimately, the Leadership Team viewed the line community as the best judge on whether the MHS accomplishes its mission. The revised mission, vision and destination statements are listed in Figure 8.

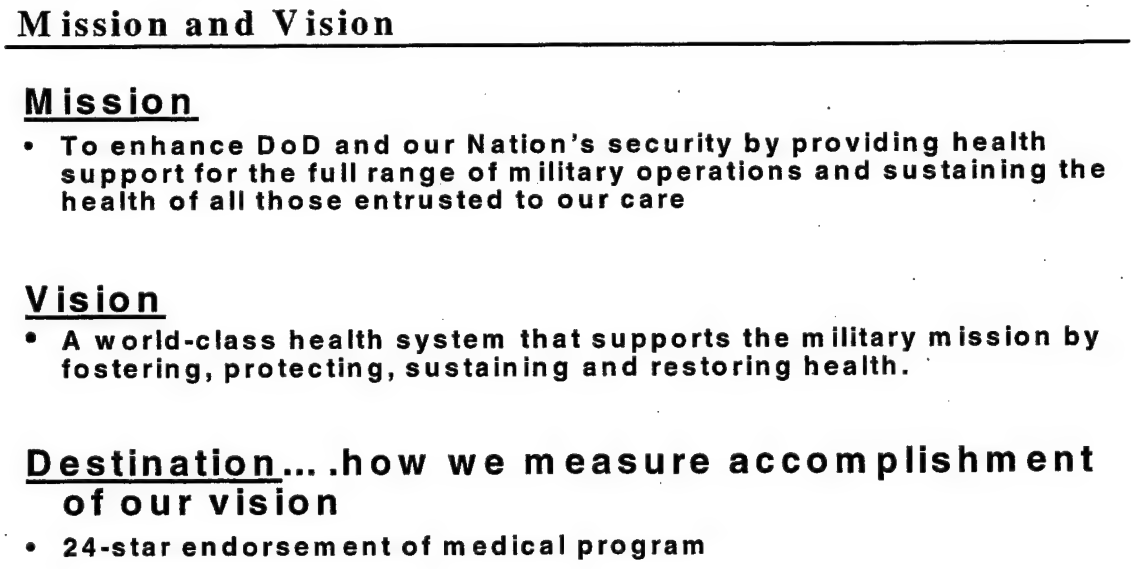

Figure 8. MHS Mission, Vision and Destination

In organizing the four main quadrants of the balanced scorecard methodology, the Leadership Team determined the appropriate progression of themes with the stakeholder perspective providing the overarching goal. The remaining scorecard architecture cascades from that viewpoint and includes the external customer perspective, representing the needs of the 8.7 million MHS beneficiaries; the financial perspective, emphasizing the MHS' role in stewardship of taxpayer's money; the internal processes perspective with three distinct themes of readiness, quality and efficiency; and the learning and growth perspective, emphasizing our workforce as internal customers. The architecture is depicted in Figure 9.

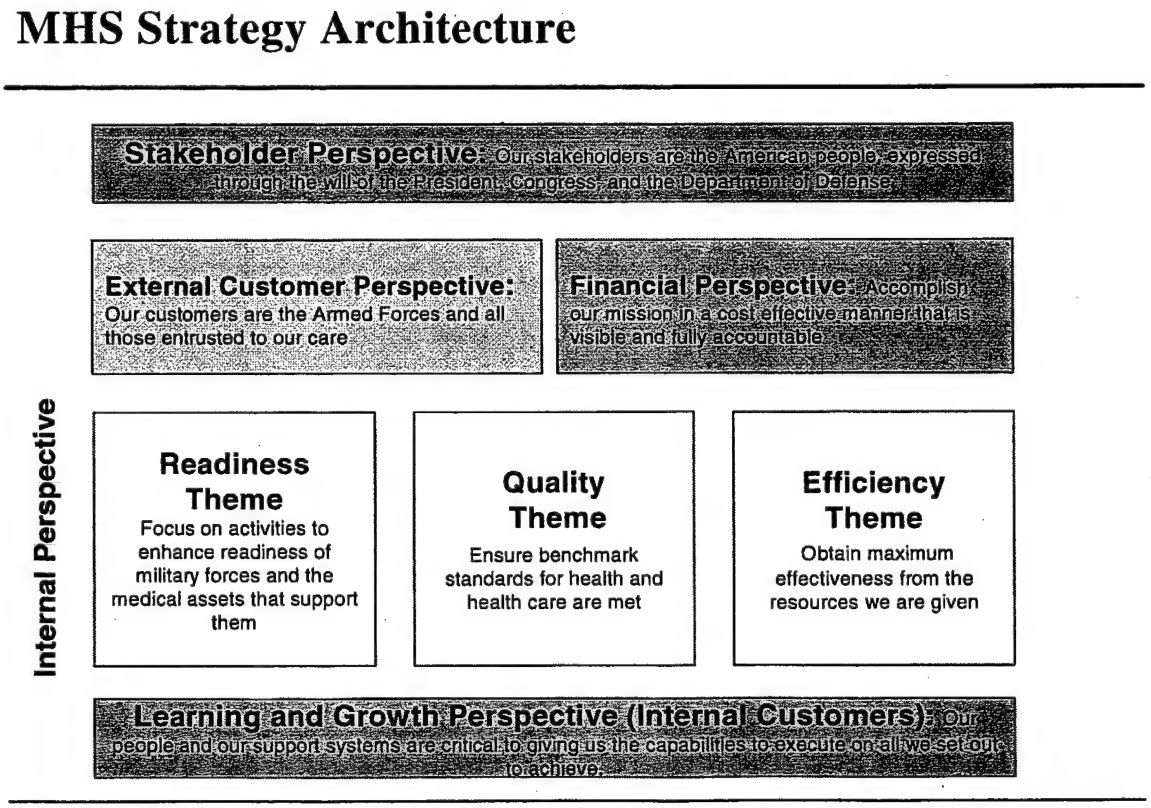

Figure 9. MHS Strategy Architecture

Based on the balanced scorecard architecture, the Leadership Team began the lengthy process of outlining objectives and defining strategic goals. To integrate team members into the process, each uniformed Service member was paired with a civilian team member and assigned a perspective to sponsor. Although the original assignments changed slightly over the time, the concept of providing both the civilian and uniformed perspective remains one of the cornerstones of the strategic formulation process. The theme sponsors, identified in Figure 10, worked with the Core Team to identify goals, recommend objectives and provide clarify objective statements.

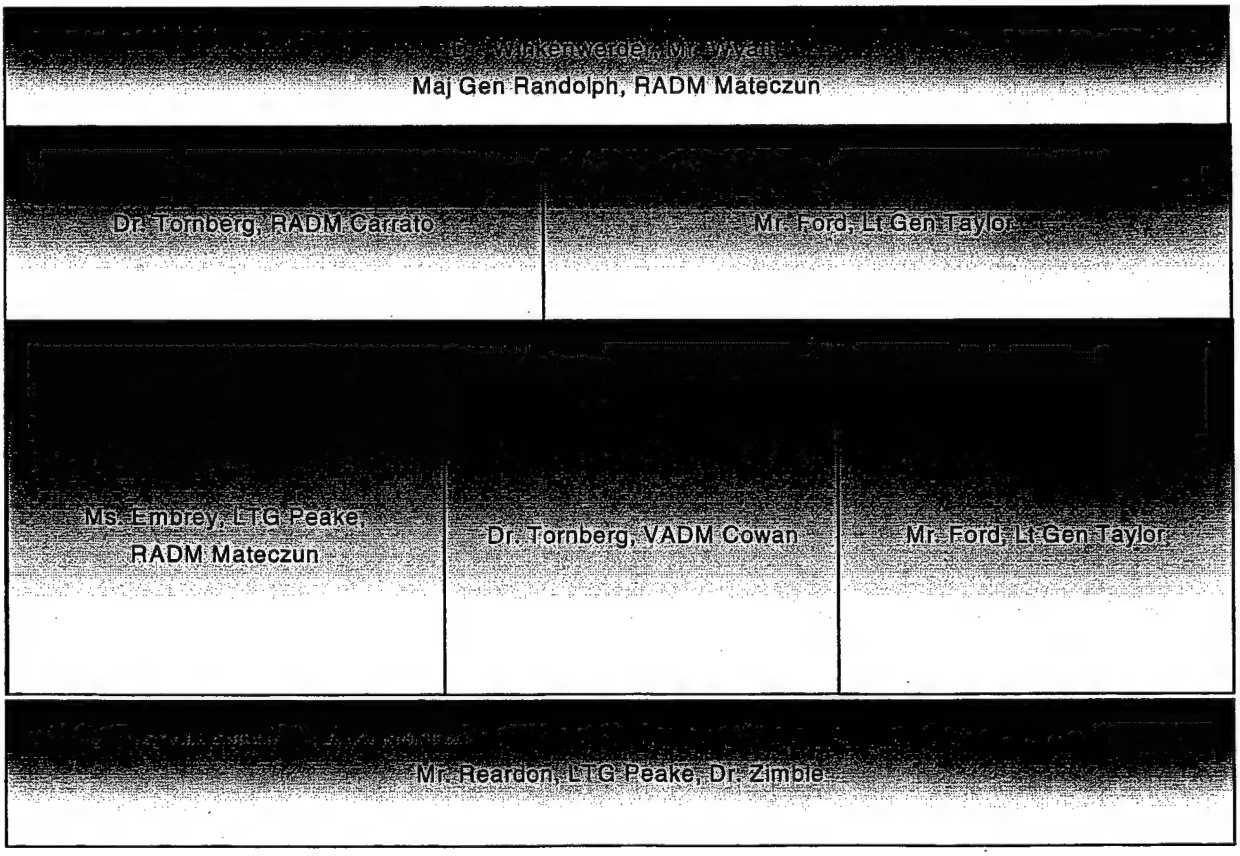

Figure 10. MHS Theme Sponsors

Once the Core Team had prepared a recommended list of objectives, the Leadership Team met to discuss and decide which objectives warranted examination at the Assistant Secretary and Surgeons General level. After considerable debate, the Leadership Team agreed to twenty objectives listed in Figure 11, the MHS Strategy Map.

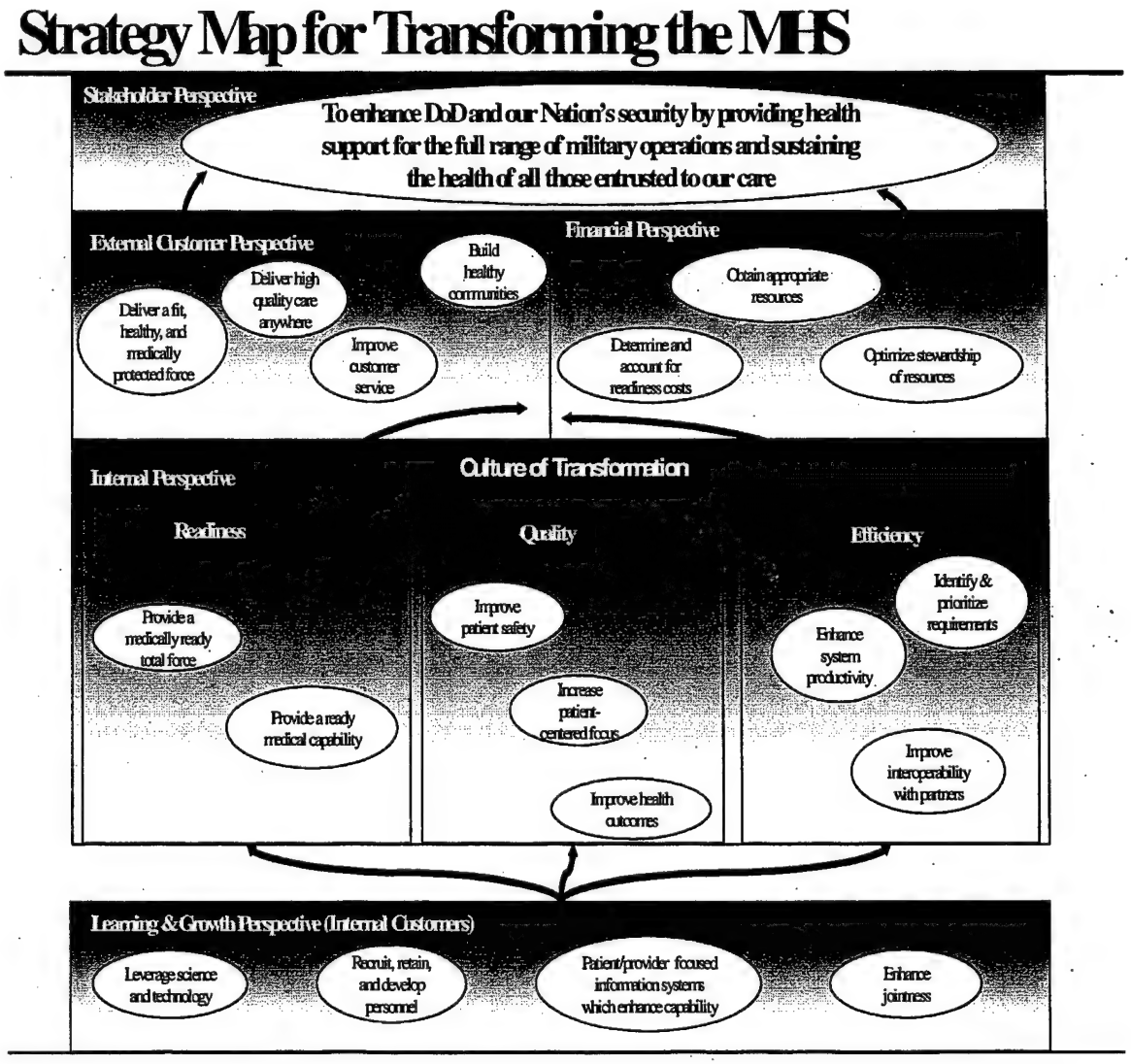

Figure 11. MHS Strategy Map

With consensus on the objectives, the Core Team identified and operationally defined appropriate performance indicators to measure success in achieving the objectives. Most of the measures are lagging indicators, measuring past performance with few leading indicators available. At present, several measures remain do not yet exist, requiring further development and data calls from the Services. The measurement worksheets for the twenty objectives are listed in Appendix C. The worksheets were extremely helpful in keeping the leadership focused on the strategic goal and required a designated measure leader to identify data sources and define who is responsible for gathering data and presenting the information to the Leadership Team during follow-on meetings.

Part of the measurement process also included proposing targets for the next five years. These stretch goals are somewhat arbitrary, especially for indicators that have yet to be built. In many cases, the targets are designed to close the gap between a baseline and some future endstate. Other targets are designed to track the implementation of new programs. The targets for each objective measure also are indicated in Appendix C.

Near the end of the 16-week formulation process, the Core Team and Leadership Team began discussion on initiatives designed to move the MHS towards the twenty objectives. However, since new programs have resource management implications, usually involving development and approval under the six-year POM submission process, few new programs were

discussed. Funded programs already in progress were identified and operationally linked to the supported objective. Potential initiatives are shown in Appendix D. Several initiatives were designed as enablers, either policy changes or business practice changes requiring few resources, setting the stage for future funded programs or new initiatives.

With the completion of initial initiative worksheets and preliminary discussion of future actions, the Leadership Team reviewed and approved the Balanced Scorecard. The revised MHS Balanced Scorecard was made available to the Services and to the directorates within Health Affairs. The formal publication of the strategic plan concluded phase three of the strategic planning process and can be found in Appendix E.

The Leadership Team also discussed the need to integrate and align the MHS strategic plan with the strategic plans of each Service and Health Affairs. Part of the integration process requires a methodology on how the metrics are reported to the Leadership Team, the frequency of reports, and how requirements generated from the Leadership Team are translated into action. The activities listed in phase four of the methodology are designed to align the organization, creating a bridge between the strategy formulation process and program implementation.

In early January 2003, each Service completed a cross-walk of its Service specific strategic plan and mapped objectives to the MHS Balanced Scorecard. As expected, the AMEDD aligned very closely to the MHS strategic plan since both use the scorecard

approach. Both the Air Force and Navy cross-walks also demonstrated clear linkages between the plans and the scorecard although their respective strategic management tools differ. In addition, Health Affairs and TMA completed a cross-walk of the current performance contracts and how they linked to the strategic plan. The results of the cross-walk indicate that at the objective goal level, there are consistent themes among the various plans, but at the measurement and initiatives level, the four cross-walks do not have the same level of continuity.

The final objective in Phase four was outlining the communications strategy for the MHS Balanced Scorecard. Part of this has been accomplished with senior leaders throughout Health Affairs and TMA utilizing aspects of the plan in internal briefings, presentations to outside parties, and staff development within the directorates. The strategic plan is posted on the Health Affairs website and is available through other communications channels to interested stakeholders and customers. However, a formal, comprehensive communications plan has not been developed.

Presently, the Leadership Team, Core Team, and other parties have devoted significant resources to produce a working strategic plan. The difficulty is implementation and a continued drive towards alignment throughout the organization. Also, as some time has passed since the November 25, 2002 Leadership Team meeting, some of the initial metrics and targets have been further scrutinized to determine if they measure what was intended, with the Leadership Team meeting once a quarter to

review the Strategic Plan.

Discussion

Differences between theory, as expressed through the project's methodology, and actual execution of the strategic planning process, highlight some of the many difficulties in executing strategic management. The discussion section of the paper identifies some of the gaps between the theoretical and the applied by considering the overall strategic management process, and each phase of the balanced scorecard development.

The Leadership Team, comprising the Assistant Secretary, the Principal Deputy, the four DASDs, the Health Affairs Chief of Staff, the three Surgeons General, TMA CIO, TMA PEO, and representatives from the J-4 Medical staff and Reserve Affairs set aside not only the four hour blocks of time for the meeting, but numerous additional hours working on various aspects of the planning process. The Leadership Team comprises the most senior members of the MHS executive management and the personal commitment of the Assistant Secretary and the leadership demonstrates a willingness to collaborate on strategic management issues.

There is an important distinction between collaboration and consensus in management decision-making. During the strategic plan development, it was not clear how the Leadership Team would manage the process. Officials appointed to senior government posts by the President often have different viewpoints and expectations than either career civil servants or military

officers. For instance, the timeframe for executing the administration's agenda is dramatically different. For the appointee, the timeframe to impact the status quo is measured in months, while the institutional bureaucracy measures change in years and decades. The policy implications of this opposing viewpoint are well-documented in the literature. An example can be found in Weissert and Weissert's book titled Governing Health: The Politics of Health Policy. Collaboration, however, does not always signify consensus.

The collaboration and consensus debate centers on the issue of control. From the ASD(HA)'s perspective, authority is defined by Title X of the United States Code. Specific authority is delegated from the Secretary of Defense with both policy and fiscal accountability and responsibility for the execution of the DHP residing with the ASD(HA). Each ASD(HA) has their own interpretation of how much influence or control they exert over the direct care system. The Services Surgeons General (SGs) have a different perspective and view the symbiotic relationship between themselves and the Health Affairs leadership as a means to an end. While recognizing the inherent control exhibited by policy and budgetary oversight, the dominant stakeholder for each of the Services medical departments are their respective Service Chiefs and it is the SGs that are directly accountable for the medical readiness mission and control over the direct care system.

The dual mission requirements and the differences in perspective of the senior leadership raise a question about what

kind of linkage network the Military Health System represents? As indicated in Figure 3, the lines of authority between Health Affairs and the Services are not succinct or direct. In some ways, the MHS as an integrated delivery system operates like a mandated federation as described by Provan (1983). Each Service operates with considerable day-to-day autonomy but generally conforms to the policies developed by Health Affairs. For this reason, the issue of control takes on added importance and should be clarified before any meaningful discussion can take place regarding strategic management. Otherwise, as in this case, executive level meetings often result in acquiescence, not consensus.

The balanced scorecard methodology is essentially a top-down process, supported by bottom-up integration of action plans and performance improvement. Overall, the strategic planning process was heavily focused on the development of performance measurements, but little discussion occurred on the integration and implementation aspects of the plan. Although the MHS senior leaders are extremely knowledgeable about military medicine and management of the Defense Health Program, most of the strategic plan development was concentrated in the hands of relatively few individuals, with subject matter experts in particular areas often not integrated into the development process. The "trickle-down" effect of information and lack of coordinated implementation within Health Affairs, TMA and with each respective Service significantly impacts successful integration of the balanced scorecard as a change management tool.

The four Leadership Team meetings produced mixed results. As currently developed, the strategic plan does not have well-defined implementation strategies and initiatives to produce meaningful and permanent change. Because of the constricted timeline for developing the planning process, some of the steps listed in the methodology were not applied rigorously and some amount of backtracking occurred as subsequent meetings reviewed previous work on objectives and measures. A positive outcome of the process was considerable and worthwhile discussion on a wide-range of topics that impact the health system.

The Core Team provided most of the input to the planning process. The team, comprising the three Deputy Surgeons General, the TMA CIO, several senior staff from HA/TMA and chaired by the TMA Program Executive Officer, performed yeoman's work to keep up with the deliverable dates and prepare the Leadership Team for the meetings. The Core Team met at least once each week, sometimes more often, and developed the initial templates for the revised mission and vision statements, defined objective goals and appropriate measures, and identified potential initiatives for FY03. It should be stated that the Core Team included six flag/general officers and four naval captains or full colonels—a very senior group of executives.

The situational analysis was minimal, primarily due to the constricted timeframe. Unfortunately, several essential components were not completed, causing additional problems during the formulation process. While having top-level management involved with the development of the scorecard is

essential, having minimal support staff to bring some of the analysis forward meant that certain steps in the strategic assessment were ignored or minimized. As indicated in the conceptual map in Figure 7, there are a range of activities that should occur with the outcome of an analytical tool, such as a SWOT matrix, to gain a full understanding of the environment and some of the underlying assumptions about "where we are", and more importantly, grapple with a complete understanding of the question, "who we are" (see conceptual map, Figure 7).

The strategic assessment process is designed to gain an understanding of both the internal and external environments. Also, the assessment allows the leadership to begin the process of identifying those internal and external forces that impact the organization. The questionnaire given to the Leadership Team did not adequately provide a complete understanding of the environment (see appendix B) or the forces that shape how the MHS functions or should function. Although other tools exist, a SWOT analysis could have provided the leadership with the opportunity to address some of the underlying assumptions about "who and where we are" before launching into strategic goals that may or may not be appropriate for the future.

The other function in the strategic assessment is to review the current strategic plan, gathering together those resources that are already creating change within the organization. The fact that the previous strategic plan was not a part of the formulation process (and in fact was only accidentally found late in the formulation process) reveals two important points.

First, previous plans were not integrated into current business operations, policy development, or resource management utilization; and second, comparisons with the previous plan found many similarities and redundancies begging the question of whether valuable time was wasted in duplicating the process. The previous plan was meticulous and complex, indicating that significant work had been done. However, the previous plan failed in two ways: it did not have senior leadership acceptance (or even knowledge), and lacked performance indicators to measure success or failure.

Certainly part of the problem with the lack of a strategic assessment can be accounted for by the way in which strategic management was applied prior to this administration. Although there was a documented "strategic plan", it existed within a small cell of action officers within Health Affairs and a tri-Service working group. Since it was not integrated into the annual business plans, the strategic plan had no relevancy to the Services or HA/TMA directorates. Each business plan, often termed performance contract or performance plan, was a stand-alone document. However, the one valuable contribution of the business plan is that the directorates understood what was required and adapted accordingly, if only to meet a requirement.

The FY02 business plan drove most of the business processes within Health Affairs. However, the Services complained that Service input was missing from the plan. Also, it did not transition from one year to the next. With the new administration, there was concern about the lack of

synchronization between one business plan and another. The FY03 business plan, as it was being developed concurrently with Service input, failed to link with outstanding objectives from the previous business plan. The ASD(HA) correctly assessed that the business plan process, as it was defined late last Spring, did not identify performance indicators clearly or link to the department's viewpoint of transformation.

The vendor training for the Leadership Team on the balanced scorecard methodology was essential to initiating discussion and adding coherence to the strategy formulation process. All fourteen members of the Leadership Team received the training, although most members were familiar with the content. The training was excellent and provided the group the opportunity to draft a proposed strategy architecture for further consideration. Since all members of the Leadership Team have significant management and strategic planning experience, there was some reluctance to spend a great deal of time on the training process. The condensed timeline also precluded much in depth training on the process.

The training for the Core Team was far more in-depth and provided the group with additional guidance on the planning process. The training package in Tab B of Appendix A is a powerful training tool on the BSC methodology, and the vendor did an outstanding job presenting the information and guiding the Core Team through the steps necessary to complete the task. One issue Core Team members quickly identified during the training meeting was the level of sophistication and the time

required to manage the planning process. Faced with a short deadline to complete the process, the Core Team recognized that some of the steps in developing the BSC would be curtailed.

In Phase two, the vendor interviewed each member of the Leadership Team regarding a number of issues. These interviews took the place of a thorough strategic assessment and did not provide the leadership with meaningful information on how to create synergy from the process. The interviews were completed, collated, and but not used to establish a common framework or establish a clear picture of the current strategic position. However, the benefit of asking the questions did generate individual reflection on how the formulation process should work and made transitioning to the next phase easier. Without completing a formal assessment, the group assumed some risk.

The development and validation of the mission, vision, and destination statements went fairly smoothly with few modifications made to the overall mission and long-term vision statements. The destination statement was much harder to articulate. For much of the formulation process, this statement was blank until one member suggested that the way in which the MHS will know if it has accomplished its mission is if the primary stakeholder endorses the MHS as the premier health system for all MHS beneficiaries. In this case, the primary stakeholder, though there would be debate on this issue later, is the Chairman of the Joint Chiefs and the Service Chiefs.

The strategy architecture was developed as the next step in the process. Using the BSC approach, the four perspectives

including financial, customer, internal processes and learning and growth were discussed in great detail. Kaplan and Norton discuss the interaction of the four perspectives as revolving around the vision and strategy with connectivity between the four perspectives as indicated in Figure 12 (Kaplan & Norton, 1996, p. 76).

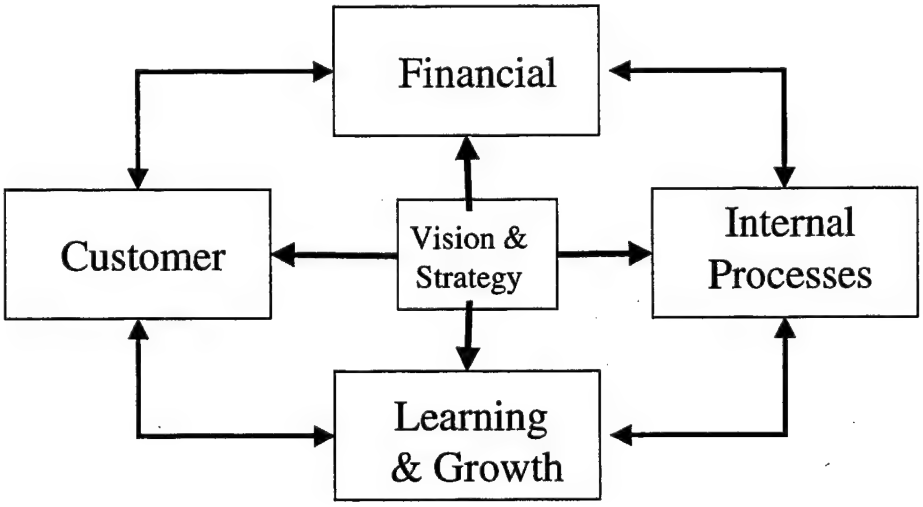

Figure 12. Four Perspectives of the Balanced Scorecard

For the MHS architecture, the four perspectives were rearranged with stakeholder on top, supported by customer and financial perspectives. The internal business process and learning and growth were subordinated below as illustrated in Figure 9. The rearrangement created a hierarchical construct instead of the usual Kaplan and Norton approach.

The internal business processes were organized under three pillars. Recognizing the dual mission of the MHS, readiness functions were differentiated from the peacetime health care

functions. The peacetime health care functions, both direct care and purchased care, were arranged to indicate the importance of both the quality of care provided and the stewardship role under which the MHS operates.

One significant area of debate involved the differentiation between stakeholder and external customer. Since readiness is a core function of the Services, the combatant commanders and the Service chiefs are both a customer and the primary stakeholder. From the Health Affairs perspective, the Secretary of Defense is the primary stakeholder. The definition of "Department of Defense" was hotly debated. In one camp that term was inclusive of the combatant commanders and Service chiefs, yet in the other camp, there was a sincere belief that the combatant commanders should be listed separately to clearly articulate their prominence as the primary stakeholder.

With the strategy architecture in place, it became apparent that in order to develop objective goals, measures, targets and initiatives that the Leadership Team and Core Team members should be assigned as "champions" to the various perspectives. The role of a champion, or theme sponsor, fulfilled two functions. First, it gained some level of executive buy-in into the planning process with a senior civilian executive assigned with a military counterpart in each perspective. Second, it moved the process forward with theme sponsors taking an active role in the development of each perspective. Figure 10 identifies the theme sponsors for each perspective. Overall, the theme sponsor concept has worked fairly well, with most of

the senior executives working diligently on the process and reporting progress to the entire team each quarter.

The development of the strategic goals went smoothly with the Core Team working with the Theme Sponsors to develop the initial list of prospective objectives. At its second meeting, the Leadership Team refined the list to the twenty objectives listed in the Strategic Map (see Figure 11), combining several objectives during the process. Other objectives were eliminated altogether. The intent of limiting the number of objectives was meant to balance each perspective and provide some focus to the management process. Each objective included an objective statement and future endstate.

The consolidation of objectives was not without consequence. In one particular case, a proposed objective of integrating the Reserve Components into the business processes (efficiency perspective) was consolidated into "provide a medically ready total force) in the readiness perspective. Unfortunately, the intent of the separate objective was not to consider only reserve integration from a readiness perspective, but also consider how the activated reserve components fit into the peacetime direct care system. The objective would also answer how to resolve disparate benefits, and how to better manage the two Reserve Components (Reserve and Guard) medical forces. Since the Leadership Team also included a senior official from OSD(RA), it made sense to keep visibility of reserve component issues on the front page with a specific objective. As events would dictate, the lack of visibility of

the reserve components issue would cause those issues to blend into the background.

The Strategy Map with its twenty objectives is balanced, with numerous linkages between the various perspectives. The Leadership Team decided that since the perspectives are ultimately all linked to each other, it was not necessary to map every linkage. The Strategy Map does provide both management and subordinates a good idea of the focus of the MHS Leadership and a management tool in which to frame management decisions.

The most serious weakness in the strategic planning process is in the determination of implementation strategies to move the MHS towards its objectives. The BSC methodology moves from developing the objectives goals to measures, a control function. Partly because of the time limitations and partly to the politics of the Leadership Team, the development of initiatives has been marginal at best. The initiatives developed so far are not actions that will produce dramatic results. In many cases, the initiatives devised are enablers, either policy or programs already under development and included in the current budget.

The literature suggests that as a purely business entity the leadership would devise adaptive strategies to expand, contract, or stabilize market share. In addition, a business entity would identify specific positioning and/or market entry strategies to maximize opportunities or limit threats. The SWOT analysis identifies those potential options. Ultimately a business links operational strategies, such as marketing, information systems, finance and human resources towards the

desired direction (Ginter, Swayne & Duncan, 1998).

The MHS does not conform to the standard definition of a business entity and difficulty developing implementation strategies. Although the objective goals are well-defined and appropriate to the MHS mission, how to create changes within the current system is problematic. The MHS has a defined benefit, a stable beneficiary group, a rigid appropriated budget process, and significant differences in corporate culture (inter-Service rivalry and the Services and Health Affairs). All of these factors are impediments to quick and easy change.

Unfortunately, as a driver of change management and integration of MHS strategic management, the MHS Balanced Scorecard may go the same way as other Health Affairs programs. The difficulty in translating the objectives into aggressive actions could result in the balanced scorecard becoming another performance measurement system. Two other significant programs, both in terms of sunk resources and lost opportunities are the optimization and population health programs. Both programs were touted as the cornerstone of the military health system. A great deal of work was done to develop and push the programs down throughout the system. However, the end result has been that both programs continue to exist in reduced form, but lack focus, direction and leadership support.

The BSC approach is first and foremost a performance measurement system. Although it balances the financial aspects with other perspectives, the process of developing objectives with corresponding measures and five-year targets does not mean

that an organization has a successful strategic plan. As a tool, the BSC provides management with a systematic method of conducting business but if the tool is used only to reflect on past performance, much of its value is lost.

The MHS has several measurement systems to describe how the system operates, how efficient it is and how resources are expended. In fact, because of the MHS' capabilities to produce data, the leadership and the Services are inundated by the amount of information that is available. The difficulty has always been deciphering data into usable information that is accurate, timely and concise.

The primary measurement system reports on the performance plan established between the USD(P&R) and the ASD(HA). Every four months, Health Affairs generates the Military Health System Executive Report (MHSER), comprising over 190 different data elements. The MHSER is the primary tool used to evaluate the performance of the MHS. It is also used as a tool to educate senior DoD leaders on how the MHS operates. The MHSER is not used as a vehicle for decision-making, but significant resources are used in preparing for its review. Whether the MHS Balanced Scorecard becomes an internal tool to only measure performance remains to be seen. The Services are particularly interested in which measurement system will be used in the future, preferring not to expend resources on a management tool that does not guide decision-making.

The final phase of the strategic planning process is alignment. The Core Team completed its mission at the November

25, 2002 Leadership Team meeting when the strategic plan was rolled out, although some of the integration work performed by the Core Team remains to be done. Primarily, there was a need to develop a communications plan and begin the process of integrating Service plans and business plans within TMA

Since the Core Team had completed its mission, a Strategic Plan Working Group was formed to carry on some of the Core Team functions and continue with the integration process. By design, the working group is much smaller than the Core Team. A senior O-6 (Colonel or Navy Captain) from each Service along with two members of the HA/TMA staff meet with the CIO to work issues generated from the Leadership Team meetings and integration tasks. One of the first group activities was to cross-walk the Service strategic plans with the MHS Balanced Scorecard. This action was completed in January, 2003. However, simply identifying common objectives between the plans is not the same thing as integrating those plans. At present, there are no plans to require integration although the new governance structure and implementation of T-Nex will require closer integration.

Part of the difficulty in integrating plans lies with the basic structure of the organization. The issues of control, responsibilities and accountability are not perfectly clear. Also, without consensus, it is going to be difficult to enact permanent change within the organization. The same can be said for the internal health affairs and TMA business processes. Since the strategic plan has been developed from the top, mid-

level managers are not integrating their business plans with the strategic plan, or changing business processes to meet targets set in the measurement worksheets (appendix C). Currently there is not a requirement for each directorate to produce either action plans or balanced scorecards.

The annual performance plans for FY03 do not yet align with the strategic plan exactly, and the FY04 budget submission is not tied-into the strategic plan at all. The HA/TMA cross-walk identified tasks that are derived from the balanced scorecard, but the DASD performance plans are not aligned to each other or in shaping the business processes within the directorates. It is business as usual for the most part. This is not meant to say that the directorates are unwilling to align their activities, but it does indicate the difficulty in creating permanent change within a bureaucracy.

The final question outlined in the conceptual map asks the question "are the goals met"? The key to understanding the development of the MHS Balanced Scorecard is asking, "Did we succeed?" The answer depends on one's viewpoint. As the vendor pointed out early in the process, success cannot be measured by first year results, but real achievement is measured by organizational changes in the second and third year with alignment throughout the organization. The Leadership Team was challenged to produce a document with objectives, measures and targets, and begin the lengthy process of creating a strategy-focused organization. The MHS still has a lot to do.

Recommendations and Conclusion

There are a number of recommendations that address some of the gaps between the theoretical construct and the actual process. While certainly not comprehensive, it may begin the process of closing some of the gaps. In addition, the strategic planning process continues. The Leadership Team continues to meet and improve the process. The Strategic Planning Working Group also continues to work on implementing the leadership's decisions. The recommendations are grouped into broad themes.

First, even though there are some significant issues that must be resolved for the MHS to be truly a strategy-focused organization, the balanced scorecard methodology offers the best hope of achieving that goal. There are a number of success stories of governmental agencies utilizing the balanced scorecard to meet their objectives. It is important to stay with the process and keep the activity moving. As in the past, relegating the current strategic plan to the bookshelf will produce no improvements in the system. The plan is simply a tool but like any good instrument, it must be used and sharpened on occasion.

Second, in order to keep the planning process moving, business activities within the Services medical departments, Health Affairs and TMA must be realigned. Each year, the department issues the Medical Planning Guidance (MPG), supporting the Defense Planning Guidance (DPG). The MPG should integrate the DPG guidance and the upcoming strategies from the scorecard and provide the Services with clear direction on what

the targets are for the upcoming year. There are numerous working groups and integrated process teams working a myriad of issues within the Department and the Services. All of these groups should be realigned to identify where their activities link to the scorecard and how they are producing the results required. A group that cannot show how it aligns to the scorecard should be disbanded, or the scorecard should reflect the objective of the group.

Furthermore, a communications plan is essential to market the strategic plan and push it down throughout the organization. In Figure 6, the step is called "making strategy everyone's job". If the strategic plan is ever going to be something more than another performance measurement system, then it must be known and adopted within all elements of Health Affairs and into the Service medical departments. This also means that each directorate should produce either an action plan or a balanced scorecard to align both the policy making apparatus and the program execution agency (TMA).

Third, the MHS Leadership must remain engaged. The ASD(HA) should consider a Strategic Management (not planning) cell within the Health Affairs front office. The current configuration allots one mid-grade officer to this function. The cell should have representation from each Service and meet monthly with the Service personnel directly responsible for strategic planning and each of the TMA directorates. The leader of this cell should be a part of all MHS senior leader meetings and provide input into policy development and program decision-

making process, advising the ASD(HA) with how the proposals align to the strategic plan. The rule must be, "if it (a proposal) does not support a strategic goal, then it should not be done."

Fourth, it makes sense to integrate those programs that have already been developed, specifically population health and optimization programs. Either the programs are the cornerstone of the MHS as advertised, or they are irrelevant and should be discarded. Several objectives look at health prevention, yet the leadership has not established whether prevention programs should be centralized. Integration should also include operational implementation strategies, such as the Information Technology strategy that already exists, and development of marketing, human resources and financial strategies. However, the central issue of control must be addressed before these programs can be effective.

Fifth, the process of monitoring strategic management can be improved. Since many of the measures are annual or periodic data, having a quarterly meeting on the metrics does not produce enough information for the Leadership Team to make educated decisions. Reducing the number of meetings to three per year still provides enough oversight of the process to be useful. Another implementation strategy should be to automate the measures so that they are immediately accessible to the leadership. The responsibility for reporting metrics should be transferred to the TRICARE Operations Center, integrating other MTF-level metric sets and Service roll-ups, with overall

responsibility for data analysis residing with the Chief Financial Officer.

Sixth, the leadership should focus on a few high priority objectives since managing twenty objectives is inefficient. Recently, the ASD(HA) designated three objectives as his highest priority: Telephone access (as an indicator for overall access), satisfaction with the health plan, and medical readiness. The three key objectives must be clearly definable, measurable and actionable. All elements of the health system should focus their energies towards those goals, but the other objectives must not be forgotten in the process. Also, the Leadership Team needs to communicate the expectations for these key objectives throughout the organization.

Finally, the leadership must address some of the organization's cultural issues. Politically speaking, coming to terms with the control issue may be difficult with acceptable resolution by all parties near impossible. Certainly, one cannot always expect consensus but without resolving this core issue, strategic alignment at the MHS level will fail. Each Service manages its medical resources differently. However, all three Services share a common perspective on their relationship with Health Affairs. The solution is open and frank dialogue. Part of a solution may be to link incentives to performance. Although the current budgeting process does not accommodate this linkage, a withhold or incentive pool potentially may generate additional interest amongst the various elements of the system. The literature suggests that linking incentives to performance

is an essential component.

To a varying degree, the MHS strategic planning process has been a success. Given that true change could take up to three years, significant progress has already been made. Recently, the ASD(HA) briefed the USD(P&R) on the MHS Strategic Plan. The briefing was well received and the leadership expects similar results with future briefings to OMB. From the perspective of the ASD(HA)'s stakeholders, the process is a success. From the perspective of the Service SGs, the process may have varying success. However, from an action officer at any level of the MHS, the strategic plan currently has little influence on their activities.

Less than a year into the process, the MHS is at a crossroads. The direction is unclear, but either the process will continue and alignment will drive change within the organization, or the MHS Balanced Scorecard will become nothing more than another internal performance management tool that does not create a vehicle for organizational change. Time will determine which path the leadership decides to take. Further research is necessary to document the process in the upcoming year. Continued development of the strategic plan is necessary to refine and institutionalize change. Unlike many other plans, the current Balanced Scorecard must be a living tool that is adaptable and capable of aligning the MHS into a strategy-focused organization. The process must not be about the tool itself. It is not about the measurements, it is about the journey and the outcome.

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Tab A, Appendix A

BALANCED SCORECARD COLLABORATIVE

Vision Meeting – Defining the Destination

Department of Defense – Health Affairs

July 31, 2002

For further information please contact:
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781.402.1117
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Agenda

- ***Introduction/Welcome*** — ***Dr. Winkenwerder***
- ***Objectives for the day*** — ***Mr. Wyatt***
  - ***DoD Health Affairs Shared "Vision "***
  - ***Agreed to Strategic Themes***
- ***Review Balanced Scorecard Approach*** — ***Mr. Bognanno***
- ***Establishment of "Terms of Reference"***
- ***Review of Approach***
- ***Next Steps – Beginning the Strategy Implementation Process***

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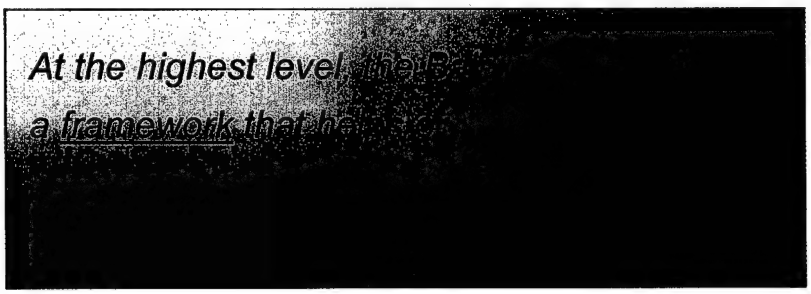
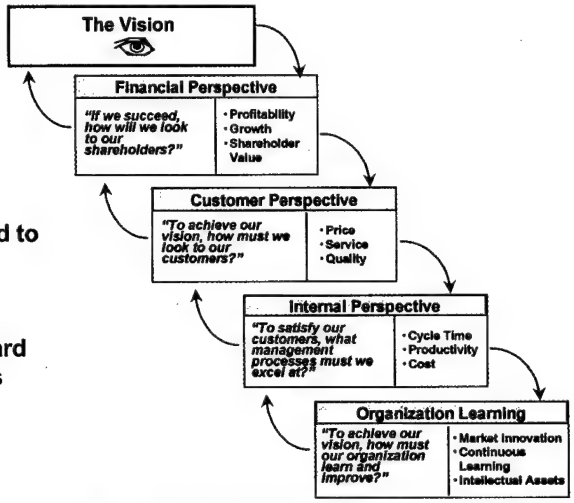
The Balanced Scorecard Is A Tool Used For Strategy Implementation



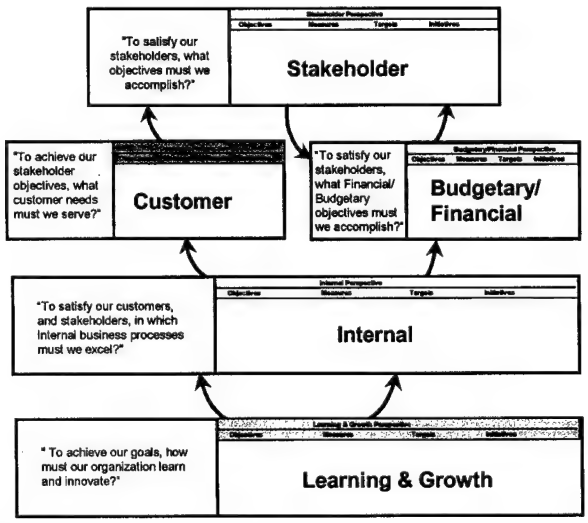
BSC Translates Strategy Into Operational Terms

Traditionally, the Balanced Scorecard provides a four-perspective framework to translate strategy into operational terms.

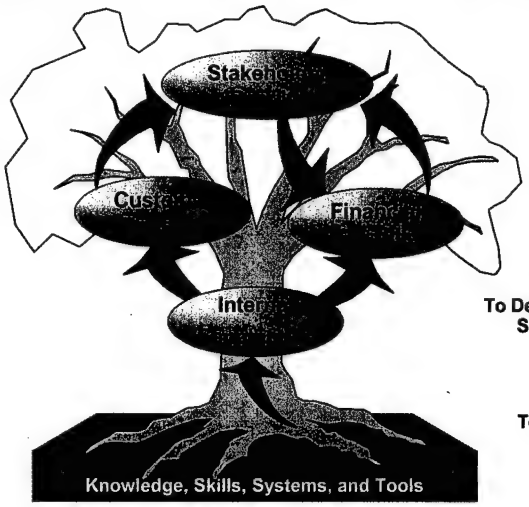
- **Measurement is the language that gives clarity to vague concepts**
- **Measurement is used to communicate, not simply to control**
- **Building the scorecard develops consensus and teamwork throughout the organization**



In The Government Sector BSC Architecture Is Modified To Reflect The Operating Environment



The Natural Cause-and-Effect Logic – "Tells the Story of the Strategy"



And Realize the Vision

To Meet our Stakeholder's Expectation

To Deliver Customer Satisfaction...

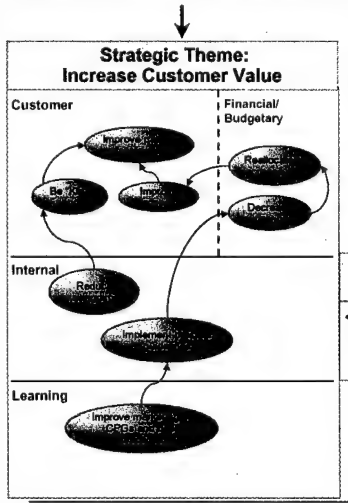
Drive Financial Responsibility...

To Build the Strategic Capabilities..

Equip our People...

Balanced Scorecard Components

Strategic Theme:
Diagram of the cause-and-effect relationships between strategic objectives



Objectives: Statement of what strategy must achieve and what's critical to its success	Measures: How success in achieving the strategy will be measured and tracked	Targets: The level of performance or rate of improvement needed	Initiatives: Key action programs required to achieve objectives
Objective	**Measure**	**Target**	**Initiative**
• Reduce waiting times	• Average emergency room wait time	• 30 minutes	• Emergency room expansion

Children's Hospital Case

What Is a Good Balanced Scorecard?

1. **Leadership Involvement**
   Strategic decision makers must validate and own the strategy and related measures
2. **Cause-and-Effect Relationships**
   Every objective selected should be part of a chain of cause and effect that represents the strategy
3. **Performance Drivers**
   A balance of outcome measures and leading measures facilitates anticipatory management
4. **Linked to Stakeholder Objective**
   Every objective can ultimately be related to a desired outcome from the stakeholder's perspective
5. **Change Initiatives**
   Aligned to Strategic Initiatives that change the behavior of the organization

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DoD Health Affairs: BSC Foundation Statements Mission - Vision - Destination

Mission defines the purpose of the organization – its Reason for Being

DoD Health Affairs MISSION:

To support DoD and our nation's security by providing health support for the full range of military deployments and sustaining the health of members of the Armed Forces, their families, and others to advance our national security interests.

DoD Health Affairs Vision:

Vision defines the Future State of the organization – its Aspiration

DoD Health Affairs Destination:

Destination Quantifies the Vision of the organization – its Outcome

DoD Health Affairs: Other Term Of Reference That Will Be Used In This Session

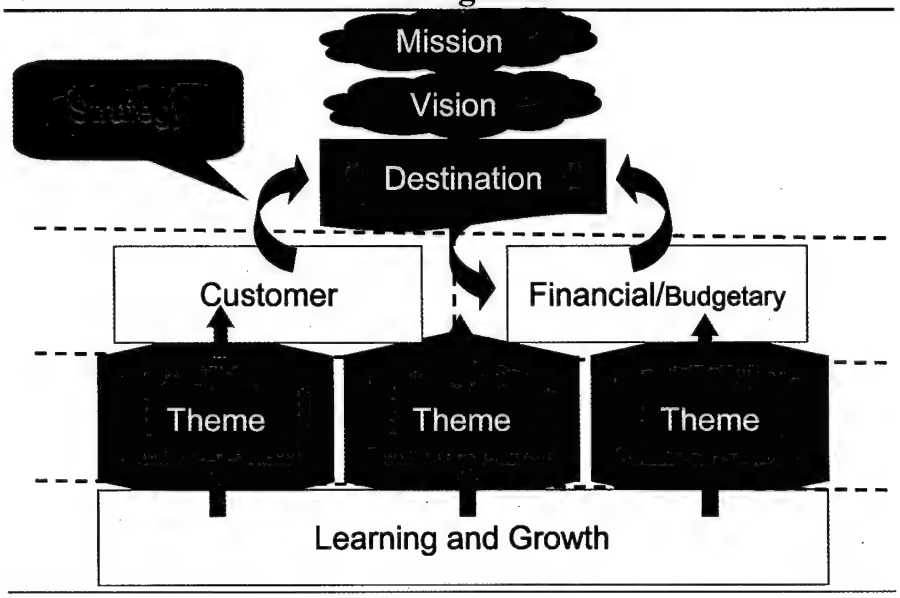
Strategy:

The Plan (Hypothesis) an organization has to achieve its Vision and Destination.

Strategic Themes:

The 3 to 5 critical things an DoD Health Affairs must do to execute its Strategy

Putting All The Term Together – The Balanced Scorecard Produces An Integrated Picture



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Approach for Today

Step 1. **Strawmodeling:** Presenting suggestions derived from information provided and previously published

Step 2. **Discussion:** Facilitated Session designed to get points of view on the table before decision

Step 3. **Decision:** Agreeing on Definitions/Terms that can be the foundation of shared strategy for DOD Health Affairs (Vision – Destination - Strategic Themes)

Suggested Sequence:

Review Mission – Craft Shared Vision - Decide Strategic Themes – Define Destination

DoD Health Affairs: Mission

Mission defines the purpose of the organization – its reason for being

DoD Health Affairs MISSION:

To support DoD and our nation's security by providing health support for the full range of military deployments and sustaining the health of members of the Armed Forces, their families, and others to advance our national security interests.

Using the Mission and your submissions lets review and discuss the DoD Health Affairs: Vision – Destination - Strategic Themes

DoD Health Affairs - Vision

Criteria for Vision Statements:

Aspirational – Long Term – Recognized - Achievable with Stretch

Example: (Illustrative only)

Become the Premier Standard Bearer for Domestic Economic Development

Strawmodel For Discussion:

To attain world class stature as a healthcare system, one that meets all wartime and peacetime health and medical needs for the active military, retirees, their families, and others

DoD Health Affairs - Strategic Destination

Criteria for Strategic Destination:

Long term – measurable – output oriented

Example: (Illustrative only)

To maximize EDA impact on distressed communities by raising individual income to above the regional average within 6 years of intervention.

Strawmodel for Discussion:

Achieve world class Healthcare System recognition by achieving HEDIS performance ratings of X by 200X with resources allocated through the regular budget process.

Draft Strategic Theme: Force Health Protection and Readiness

Inputs provided:

- Air Force — "Ensure Readiness capabilities at home and deployed"
- Army — "Readiness of our Armed Forces"
- Navy — "Force Health Protection is our primary mission"
- TMA — "Meeting our Readiness mission for Homeland Defense and Deployed Forces... while preserving comprehensive quality healthcare to all eligible beneficiaries".

Draft Strategic Theme:

Force Health Protection and Readiness

Defined as:

Our capacity/capability as a healthcare system to ensure the health readiness of our Forces that allows us to meet our peacetime and war time obligations.

Draft Strategic Theme: Quality Healthcare

Inputs provided:

- Air Force — "Foster Health"
- Army — "Health of our population"
- Navy — "Preserving Health"
- TMA — "Quality healthcare to all eligible beneficiaries".

Draft Strategic Theme:

Quality Healthcare

Defined as:

Providing access to quality health facilities and medical services to the eligible population

Draft Strategic Theme: Operational Excellence/Optimization

Inputs provided:

• Air Force	"Rebuild Direct care System"
	"Establish strong networks to support the direct care system"
• Army	"Level of Performance/quality"
	"Strategic Objective: Business Processes"
• Navy	"Optimization"
• TMA	"Development, acquisition, and transition of the T-Nex family of contracts while enhancing customer (patient and provider) satisfaction and minimizing cost growth of health care".

Draft Strategic Theme:

Operational Excellence/Optimization

Defined as:

Providing an effective and cost efficient health care system for all eligible populations

Agenda

- ***Introduction/Welcome*** — ***Dr. Winkenwerder***
- ***Objectives for the day*** — ***Mr. Wyatt***
  - ***DoD Health Affairs Shared "Vision "***
  - ***Agreed to Strategic Themes***
- ***Review Balanced Scorecard Approach*** — ***Mr. Bognanno***
- ***Establishment of "Terms of Reference"***
- ***Review of Approach***
- ***Next Steps – Beginning the Strategy Implementation Process***

Publish and Distribute Foundation Statements

Publish and Distribute Output of Vision Meeting **NLT August 1, 2002**

DoD Health Affairs: Vision Statement
Destination Statement
Strategic Themes (Definitions)

Confirm/Train BSC Core Team

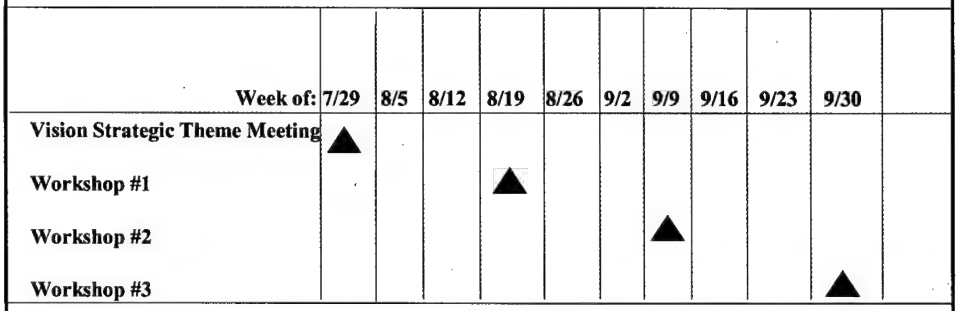
Identify and confirm "Core Team Members' **NLT August 1, 2002**

Core Team Lead	MG Randolph
Core Team Members	DSGs (proposed)

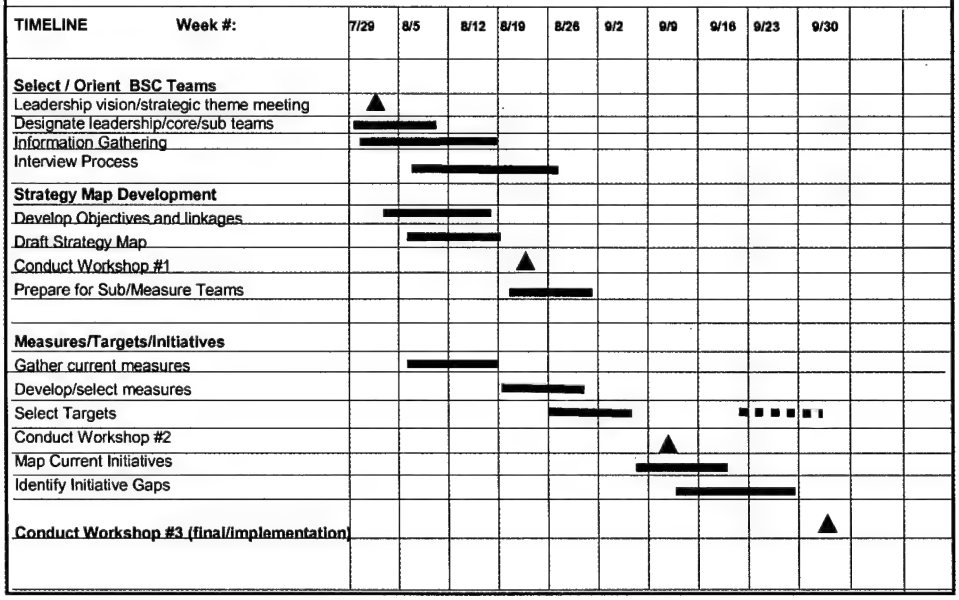
Provide Orientation/Training to Core Team Members **NLT (date)**

Provided by BSCol

Project Plan – Major Meeting Dates



Project Plan – Tasks and Timeline



Appendix - Submissions

Air Force

Army

Navy

TMA

USAF

The following lists the broad and crosscutting themes:

Broad Themes (Top Priority):
Ensure readiness capabilities at home and deployed
Rebuild the direct care system
Foster health
Establish strong networks to support the direct care system: T-NEX, VA, Civilian Partnerships

Crosscutting Themes (Next Priority):
Value MHS Personnel
Field Appropriate IM/IT Architecture
Field and Fully Utilize Actionable Performance Measure

The broad horizontal bars are listed in priority, but are not

USAF Continued

The broad horizontal bars are listed in priority, but are not numbered intentionally. These are the broad issues that have MHS implications. The vertical bars are "crosscutters" and impact each broad/horizontal issue. As these crosscutters improve, they will provide the leverage needed for the broader issues.

U.S. AIR FORCE

Strategic Themes in Support of the MHS

Value MHS Personnel	Field Appropriate IM/IT Architecture	Field and Fully Utilize Actionable Performance Measures

Ensure readiness capabilities at home and deployed

Rebuild the direct care system

Foster healthy population

Establish strong networks to support the direct care system: T-NEX, VA, Civilian Partnerships

Integrity - Service - Excellence

Army

MHS Vision Statement:

Elements of the Vision:

- Health of our population
- Readiness of our Armed Forces
- Fulfillment of the Promise... an entitlement
- Expectations of congress/service members/military leadership
- Level of performance/ quality
- Stewardship

Army Objectives

Customer:

- Fit and deployable service members
- Medically protected
- Least cost
- Obviate long term health consequences of deployment
- Simple interface "B to C"
- Confidence in

Processes:

- Policy development
- Business
  - Purchase of Health care "BtoB"
  - Claims Management
- Supply Management
  - Purchase
  - "B to B"
  - Standardization vs. Flexibility for Patients
- Equipment Management:
  - Life cycle management
  - Programmatic Review
  - Programmatic funding
  - Corporate funding / promulgation
  - Technology Insertion (AMP)
- Contract Management:
  - Development
  - Monitoring
  - Change order management
- Marketing
  - Continuous needs assessment
  - Branding
  - Communication / advertisement

Army Objectives continued

- Health Plan Management
  - Dispute adjudication
  - Standards of benefit determination
- Resource development
  - Congress
  - OSD
  - OMB
- Resource allocation
  - Business case analysis (timeliness – value add)
- Mobilization:
  - Health Status Screening (pre/post)
  - Civilian Health Industry / Service / Installation interface

Organizational Growth & Development:

- Common Sense of Purpose / Values
- Culture of stewardship (productivity) and Service (to Nation & Patients)
- Life cycle management

Financial:

- Programmatic Resourcing for the complete mission

Army Strategies

Strategies:

- Core of capability is the Direct Care System
  - Readiness platform
  - Benefit platform
  - AC force health protection enabler
- Leverage Information Technology (perhaps the greatest potential benefit): Leveraging the Federal Health Sector and bridging to the Civilian Health Industry around the patient data set driven by standards that set the industry axis
  - Foxhole to CONUS and across service... common longitudinal patient picture ... MEPS thru VA care . . . . Cradle to Grave
  - Standard data elements... common demographic elements
  - Common language format.. XML?
  - Link episode of patient care to the provider (providing entity)
  - Link ancillary services thru episode of care to the providing entity
- Incorporate the Civilian Health Care Industry to fill the gap on a business case driven approach
- Human Resource – Our People
  - Environment of worth
- Funding: A strategic issue: cannot rely on a standard DoD growth/inflation rate, so link to an appropriate Industry Index.

Navy

NAVY MEDICINE
Steaming To Assist

A Transformational Approach to Improve the Military Health System

Health System Optimization & Preserving Population Health

TMA

The three biggest issues that TMA sees looming on the horizon that need to be addressed are:

- **Development, acquisition, and transition of the T-Nex family of contracts while enhancing customer (patient and provider) satisfaction and minimizing cost growth of health care.**
- **Development and implementation of a new Regional Governance structure.**
- **Meeting our Readiness mission for Homeland Defense and Deployed Forces while providing comprehensive quality healthcare to all eligible beneficiaries.**

Tab B, Appendix A

BALANCED SCORECARD COLLABORATIVE

Developing the Strategy-Focused Organization at the Military Health System

Core Team Training

08-07-2002

For further information please contact:
MG Randy Randolph, Maj. Baird or
Ted Jackson (BSCol)

Balanced Scorecard Collaborative, Inc. • 55 Old Bedford Road • Lincoln, MA 01773 • Tel: 781.259.3737 • Fax: 781.259.3389 • bscol.com

Introductions

- Let's take a few minutes to introduce ourselves and the project that the Leadership team has undertaken.
- Name, understanding of the Balanced Scorecard, experience with measurement systems

Core Team Training Agenda

- *The BSC Introduction (Concept and Development Process) – 90 minutes*
- *The Design Center - 45 minutes*
- *The Military Health System Architecture and Timeline - 15 minutes*
- *Next Steps - 30 minutes*

Introduction to the Balanced Scorecard

1.1 The Balanced Scorecard: Origins and Concept

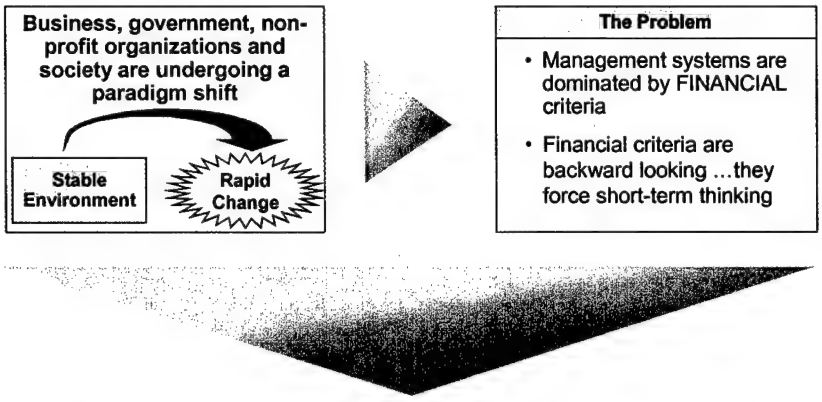
1.2 Critical Components of a Bala

1.3 The Balanced Scorecard De

1.4 BSC Implementation

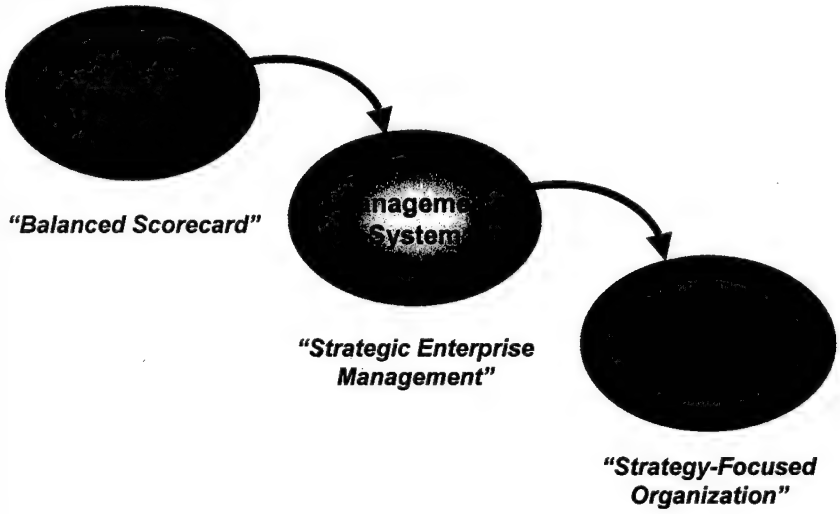
1.5 BSC Development: The Leader's

The Problem Balanced Scorecard Set Out to Solve



Conclusion:
YOU CAN'T GET TO THE FUTURE BY LOOKING BACKWARD

From Measurement to Change Management: Evolution of the Balanced Scorecard



The New World of Government Agencies

Today's Agencies Are Expected to Be:

- Competitive (outsourcing)
- Accountable
- Customer-friendly
- Fiscally responsible
- e-Enabled
- Performance-Focused (GPRA)

External world is highly unstable, so planning systems must deal with uncertainty

1. Strategy is a Hypothesis
2. Strategy is a Dynamic Process
3. Strategy is Everyone's Job
4. Organizations are systems that must sense, experiment, learn, and adapt

*Adapted from "Planning is Dead, Long Live Planning, " Jos. Fuller, Across the Board, March 1998

There Are Four Barriers to Strategy Implementation

The Vision Barrier

Only 5% of the work force understand the strategy

The People Barrier

Only 25% of managers have personal objectives and reward / recognition linked to strategy

9 of 10 organizations fail to execute strategy

The Management Barrier

85% of leadership teams spend less than one hour/ month discussing strategy

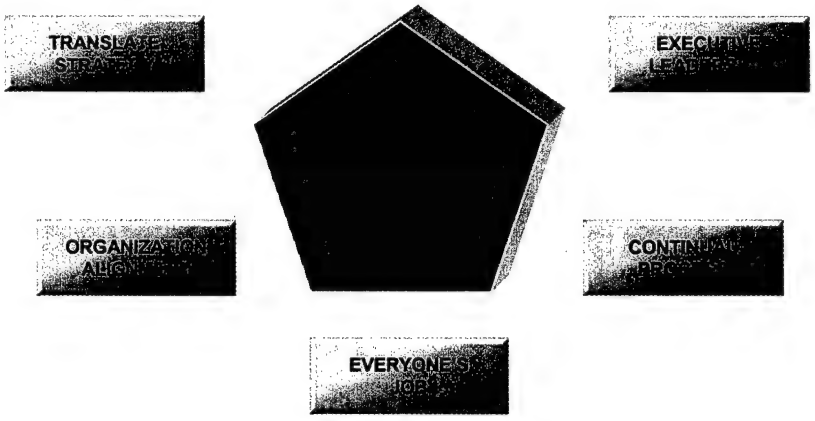
60% of organizations do not link budgets to strategy

The Resource Barrier

Today's Management Systems Were Designed to Meet The Needs of Stable Organizations That Were Changing Incrementally

You Can't Manage Strategy With a System Designed for Tactics

The Answer:
The Creation of a "Strategy-Focused Organization"



Principles of a "Strategy-Focused Organization"

1. Translate the strategy to operational terms	... so everyone can understand
2. Link and align the organization around its strategy	... this creates a "line of sight" from "flagpole to the foxhole"
3. Make strategy everyone's job	... through personal contribution to strategic implementation
4. Make strategy a continuous process	... through organizational learning and adapting
5. Provide a change agenda	... for executive leadership to mobilize change

Balanced Scorecard Users Have Been Executing Their Strategies Reliably and Rapidly

CIGNA Property & Casualty

1993	–	$275 loss
1998	–	Top quartile
	–	$3b spin-off

Chemical Bank

		Profits
1993	–	X
1998	–	20X

Brown & Root Engineering (Rockwater)

1993	–	Losing money
1996	–	# 1 in niche (growth & profits)

ATT Canada

1995	–	$300M loss
1998	–	Customer base doubles
1999	–	$7b spin-off

Duke Children's Hospital

1996	–	$11 MM loss
2000	–	Net margin increase of $15 MM vs.1996

UC / San Diego

1999 RIT / USA Today Quality Cup for Education

Scorecard Benefits for Your Organization?

- Clarify the vision
- Gain consensus and ownership
- Align the organization
- Integrate strategic planning
- Drive resource allocation
- Improve management effectiveness

The Balanced Scorecard is a tool and framework with a number of applications that can be tailored to the situation.

Introduction to the Balanced Scorecard

1.1 The Balanced Scorecard: Origins and Concept

1.2 Critical Components of a Balanced Scorecard

1.3 The Balanced Scorecard Development Framework

1.4 BSC Implementation

1.5 BSC Development: The Leader's Role

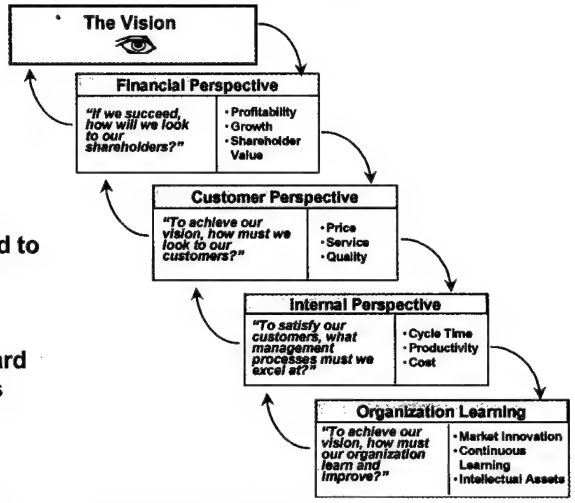
How Does a Balanced Scorecard Assist in Strategy Implementation?

At the highest level, the Balanced Scorecard is a framework that helps organizations

BSC Translates Strategy Into Operational Terms

Traditionally, the Balanced Scorecard provides a four-perspective framework to translate strategy into operational terms.

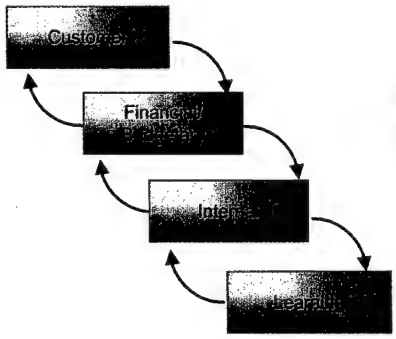
- **Measurement is the language that gives clarity to vague concepts**
- **Measurement is used to communicate, not simply to control**
- **Building the scorecard develops consensus and teamwork throughout the organization**



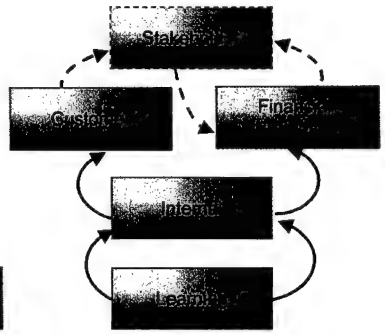
Model Adaptations for Government Sector

In the government sector, various model adaptations have been made to reflect the unique mission of the agency.

City Organizations

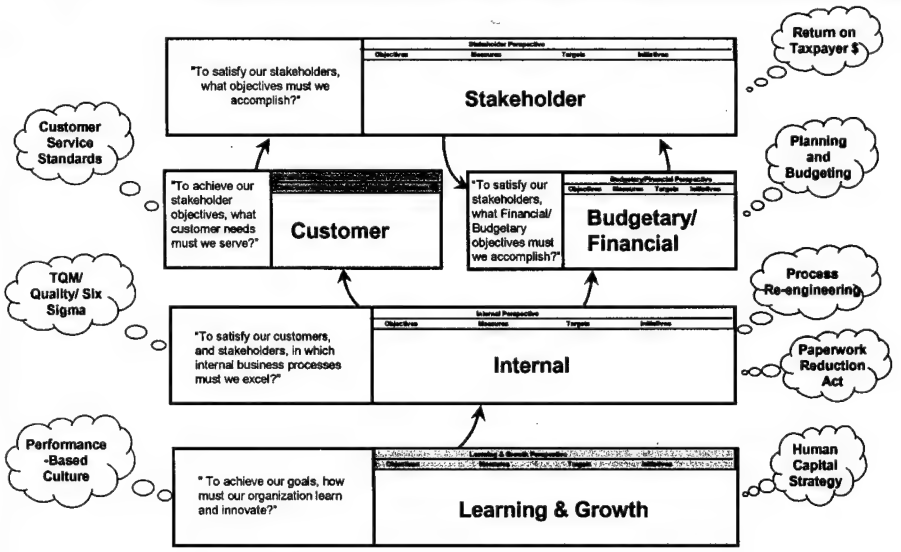


State/Federal Agencies

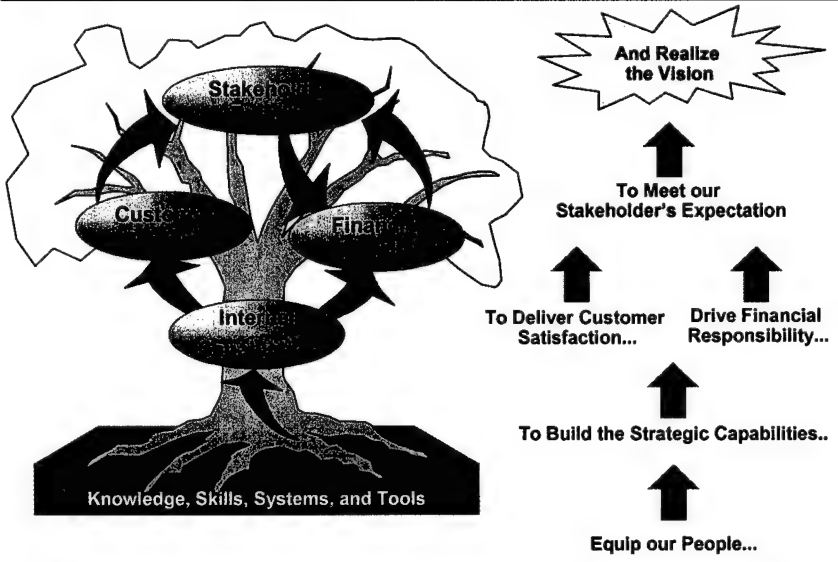


It is **critical** that the organization communicates its mission in a way the **organization understands**.

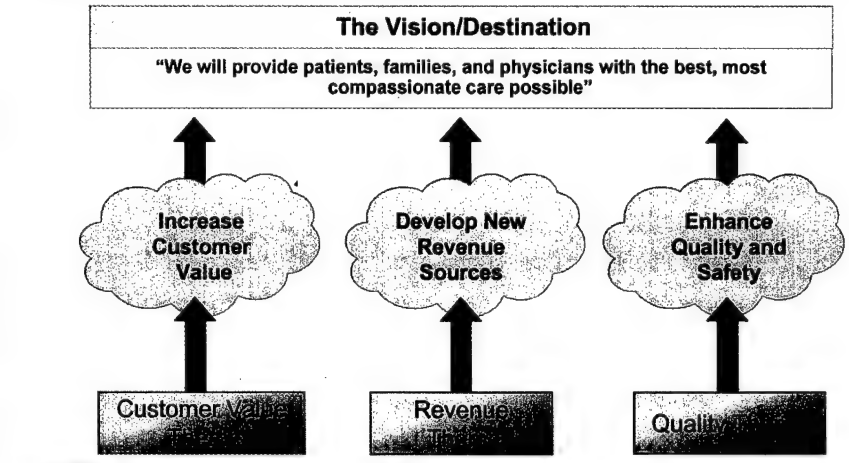
BSC — The Integrator of the Best Management Practices



The Natural Cause-and-Effect Logic – "Tells the Story of the Strategy"

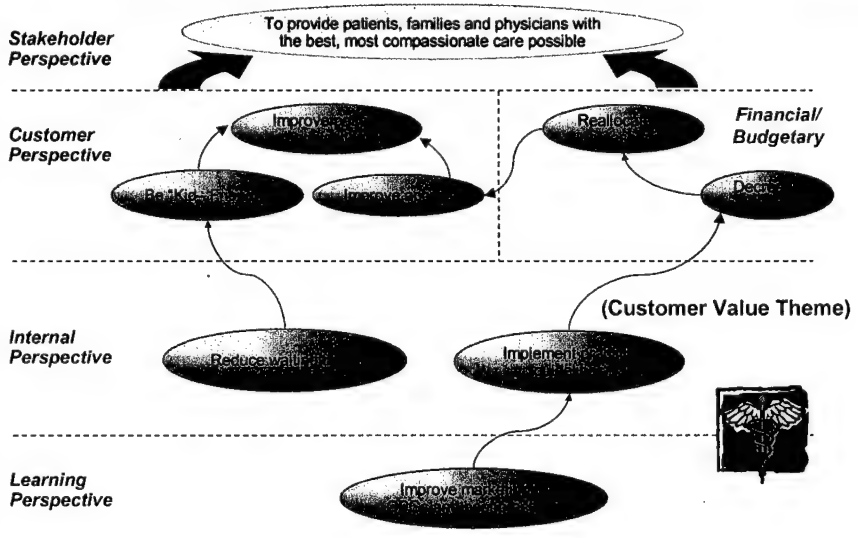


A Good Balanced Scorecard Will Tell the Story of Your Strategy



Case Study: Children's Hospital Strategy Consisted of Three Strategic Themes

Strategic Objectives Form a Theme Through a Set of Cause and Effect Relationships



There Is a Balance Between Outcome Measures and Performance Drivers

	Lag Measures		Lead Measures
Financial Perspective	• Medical Staff/Support Staff • Supply Cost/Patient		
Customer Perspective	• Patient Satisfaction • Emergency Dept. — % left without treatment		
Internal Perspective	• Average Emergency Room Wait Time • % Practice Guideline Adherence (based on spot checks)	← ←	• # Of Emergency Room Beds Available • % Practice Guidelines Established/Updated
Learning Perspective	• % Aware of CPGs and Best Practices	←	• Hours Training/Employee

Some Measures Should Redefine a Process or Cause the Organization to Change Behavior

	Lag Measures	Lead Measure
Internal Perspective	• Average Emergency Room Wait	• # of emergency Room Beds Available

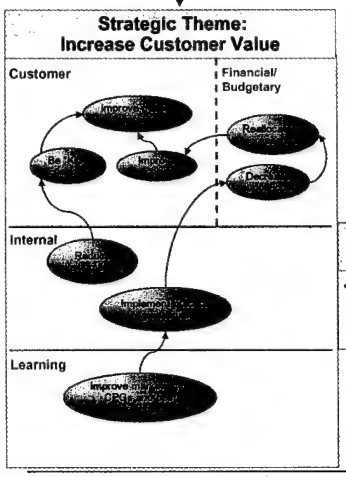
Strategic Initiatives

"Emergency Room Expansion"

1. Forecast Requirements
2. Identify Funding Sources
3. Identify Replacement Space for Adjacent Departments
4. Plan Project
4. Implement
5. Rollout

Balanced Scorecard Components

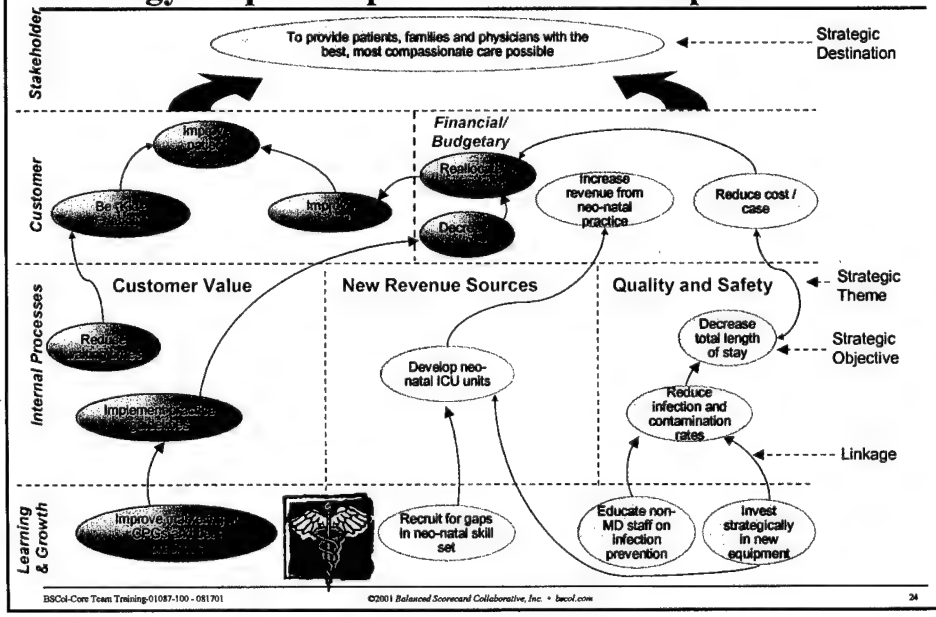
Strategy Map:
Diagram of the cause-and-effect relationships between strategic objectives



Objectives: Statement of what strategy must achieve and what's critical to its success	Measures: How success in achieving the strategy will be measured and tracked	Targets: The level of performance or rate of improvement needed	Initiatives: Key action programs required to achieve objectives
Objective	**Measure**	**Target**	**Initiative**
• Reduce waiting times	• Average emergency room wait time	• 30 minutes	• Emergency room expansion

Children's Hospital Case

Strategy Map Example – Children's Hospital

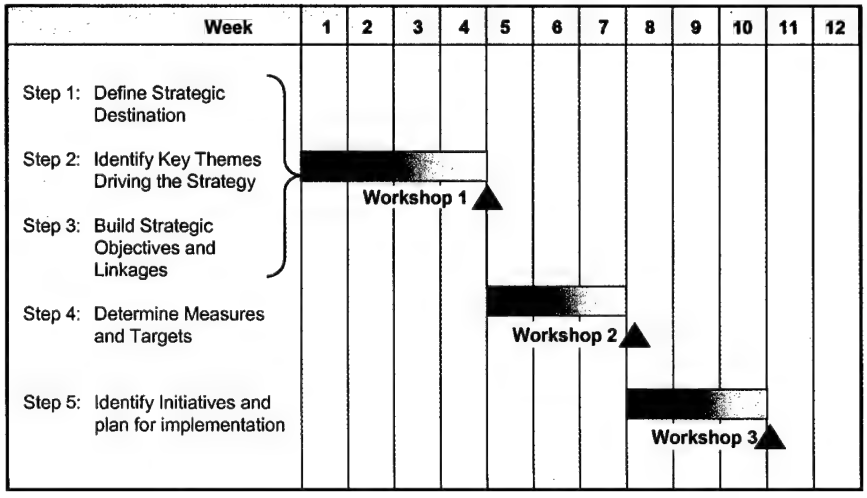


What Is a Good Balanced Scorecard?

A good Balanced Scorecard will "tell the story" of your strategy

1. **Leadership Involvement**
   Strategic decision makers must validate and own the strategy and related measures
2. **Cause-and-Effect Relationships**
   Every objective selected should be part of a chain of cause and effect that represents the strategy
3. **Performance Drivers**
   A balance of outcome measures and leading measures facilitates anticipatory management
4. **Linked to Stakeholder Objective**
   Every objective can ultimately be related to a desired outcome from the stakeholder's perspective
5. **Change Initiatives**
   Aligned to Strategic Initiatives that change the behavior of the organization

Typical Balanced Scorecard Project Schedule



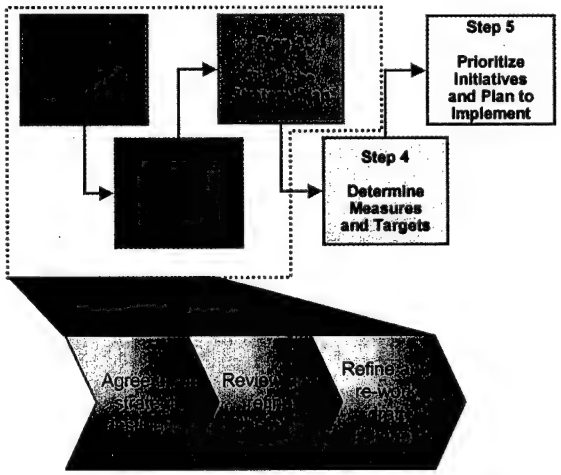
BSC Development Teams

Core Team

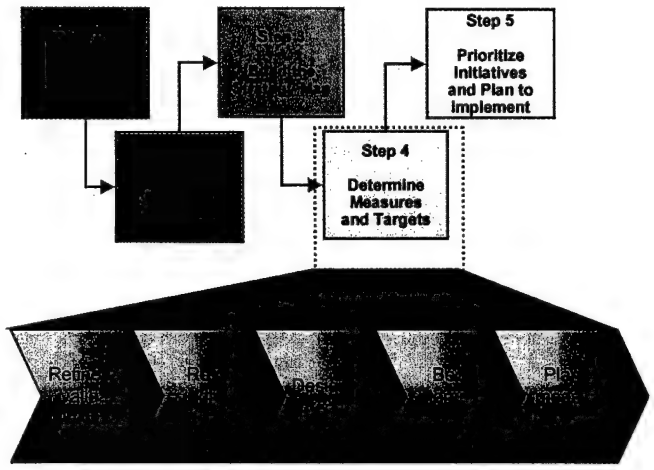
Leadership Team

Sub-Team/Measurements Team

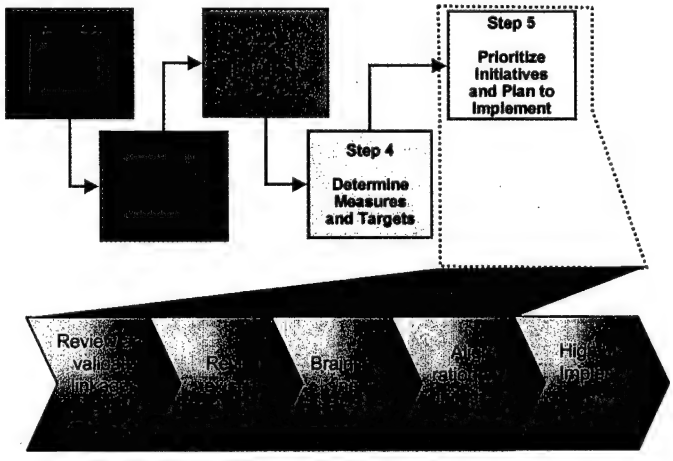
Workshop 1: Finalize Strategy Map



Workshop 2: Measures Development



Workshop 3: Initiative Prioritization and Implementation Planning



Introduction to the Balanced Scorecard

1.1 The Balanced Scorecard: [illegible]

1.2 Critical Components of a Bal[illegible]

1.3 The Balanced Scorecard D[illegible]

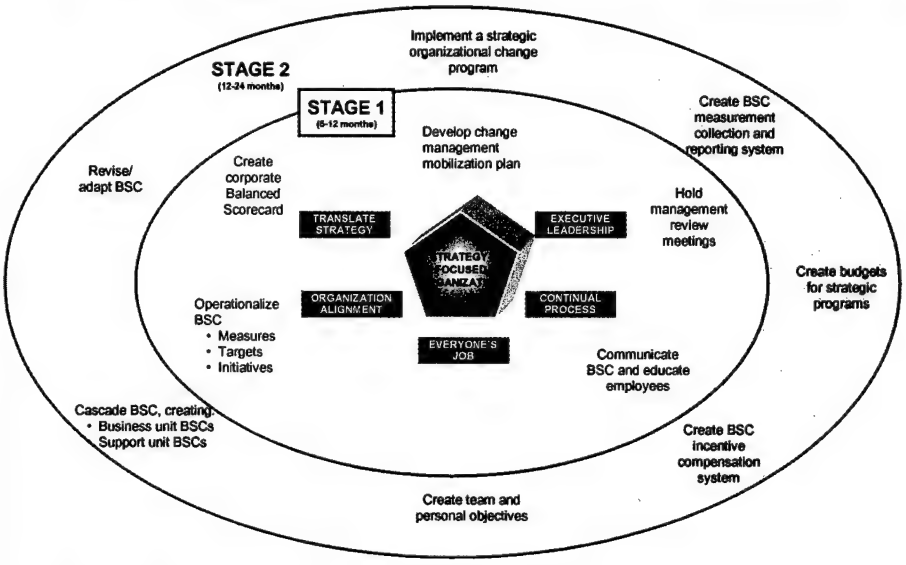
1.4 BSC Implementation

1.5 BSC Development: The Leadi[illegible]

Making the BSC Operational

- Steps to get to First Report:
  - Strategic themes, objectives, and linkages finalized
  - Missing measures and targets profiled
  - Accountability for reporting on measurements established
  - Reporting process and system established
- Hold first BSC review meeting within 60 days

Balanced Scorecard Implementation Can Proceed in Stages



Implementation Plan Creation

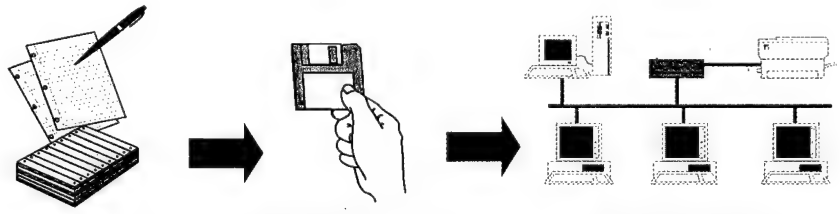
- Accountability
  - For themes, objectives/ measures, BSC program
- Management Reporting and Review
  - Creation of a BSC reporting system
  - Reporting reviews for "learning not control"
- Strategic Learning
  - From Strategic Planning to "Strategic Management"
- Cascading
  - BSCs development for business units (SBU) and service units (SU)

Setting Accountability for BSC Implementation Must Be Clear

Members of the Leadership Team must set / accept responsibility for such activities as:

- Ownership through stewardship
  - Monitoring and reporting on the status of BSC themes, initiatives, measures, targets, projects
- Leadership for operationalizing the BSC
  - E.g., developing missing measures, communications, reporting
- Responsibility for cascading the BSC through the organization and management of change

Vehicles for Reporting Mature Over Time, but the Absence of Automated Solutions Should Not Slow the Process



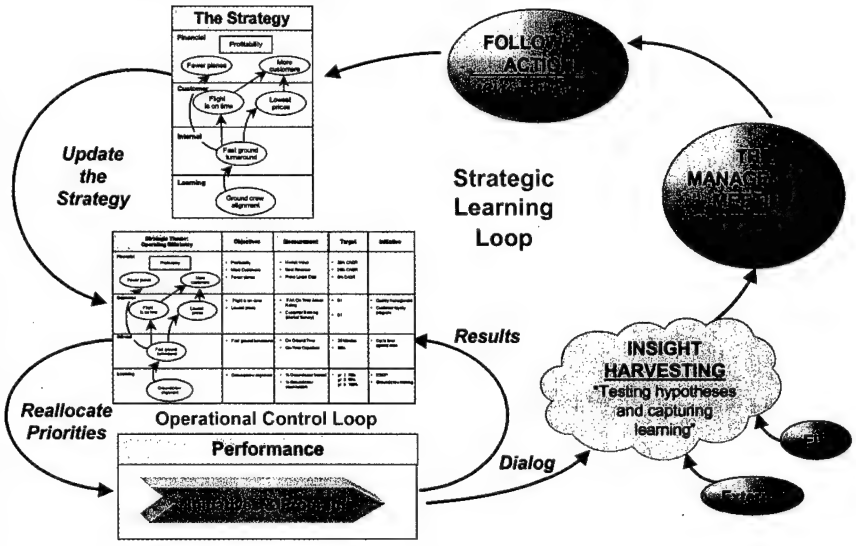
Paper based; burden on individuals

Computer tools, but burden still on individual if not connected and automated

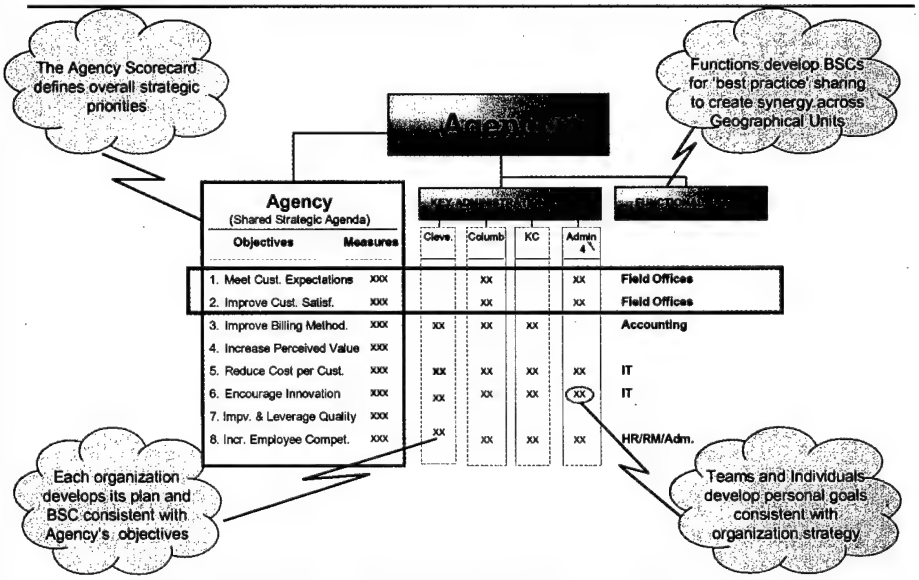
Computer tools, connected, automated reporting — burden moves to system

First Report (60 days) — **Year 1** — **Year 2**

BSC Enables the Leadership Team to Engage in Strategic Learning



Cascading the Balanced Scorecard Aligns the Organization



Introduction to the Balanced Scorecard

1.1 The Balanced Scorecard: Origins

1.2 Critical Components of a Balanced Scorecard

1.3 The Balanced Scorecard Development Process

1.4 BSC Implementation

1.5 BSC Development: The Leader's Role

Leadership Commitment Is Critical in BSC Development and Implementation

- BSC must be driven from the top
- There must be a clear sense of purpose
- The leadership team must lead the cascading of the BSC through the organization
- Change requires persistent and assertive leadership, because...

A Balanced Scorecard Program Is Not a "Metrics" Project, It Is a "Change" Process

A successful Balanced Scorecard program starts with a recognition that it is not a "metrics" project, it's a "change" process.

In this context leaders must:

1. **Create the climate for change**
   - **Unfreeze the organization**
   - **Show the need for change**
2. **Create the leadership team**
   - **Break down functional bias**
   - **Foster "advocates"**
3. **Create the vision and strategy**
   - **BSC as a "visioning process"**
   - **BSC to clarify the strategy**
4. **Create team accountability**
   - **Accountability for cross-functional strategic themes at leadership level**
5. **Change the culture**

How Leaders Can Be Effective: Best Practice Attributes

- Lead by example – Be visible and participate in the development and implementation process
- Manage barriers - Understand potential roadblocks in BSC acceptance and plan to manage them
- Be positive- Decide to be positive about Balanced Scorecard and stay that way (it will rub off)

The Focus Is on Strategy

Core Team Training Agenda

The BSC Introduction (Concept and Development Process) – 90 minutes

➡ *The Design Center - 45 minutes*

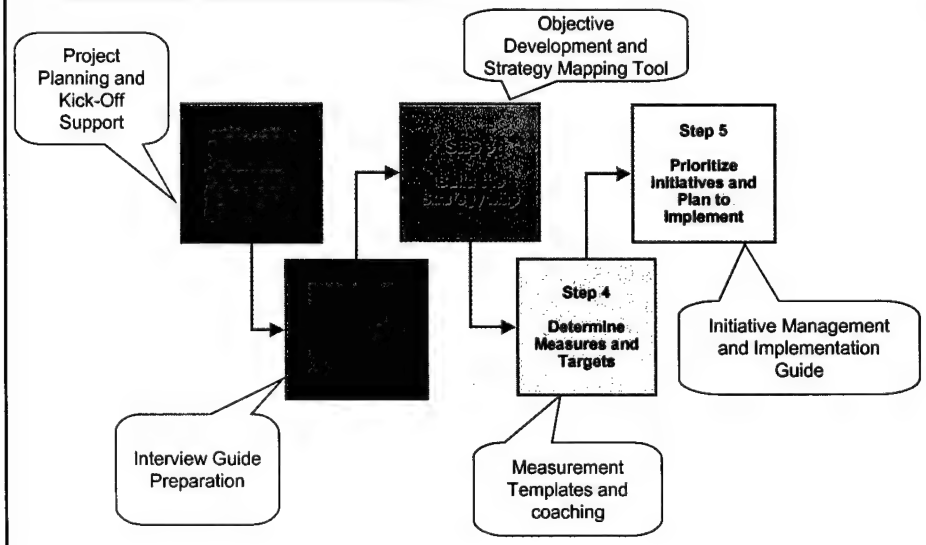
The Military Health System Architecture and Timeline - 15 minutes

Next Steps - 30 minutes

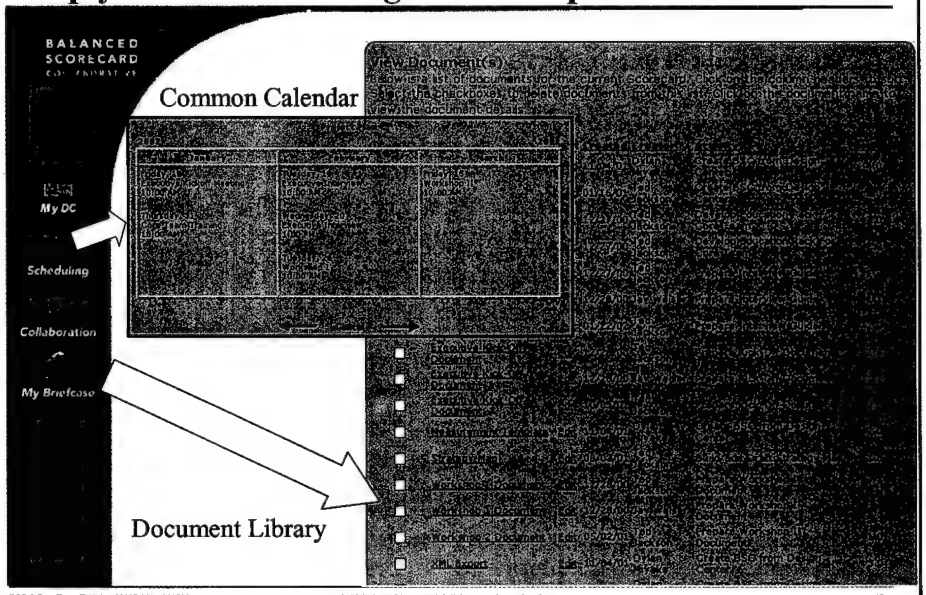
Overview – What is the Design Center?

- A web-based tool created to help organizations build their Balanced Scorecard using the proven Kaplan-Norton methodology.
- Designed to manage the process of creating a BSC with a diverse core team. The tool will give the users project management support and coaching that leverages the development process.
- Provides you with:
  - Templates and wizards to take you through the steps
  - Multimedia coaching and collaboration
  - Project management support
  - Document Library and common calendar
  - Language support and export capabilities

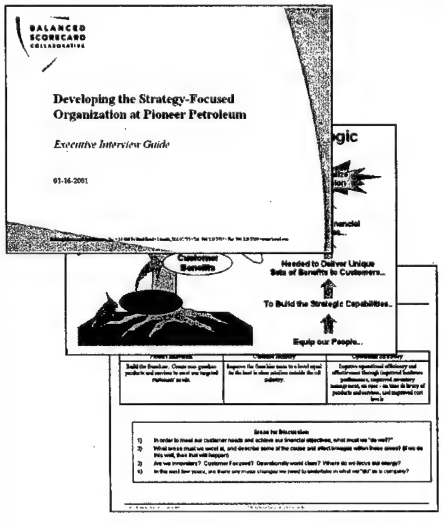
The Design Center accelerates your pace through the five-phase Norton-Kaplan methodology



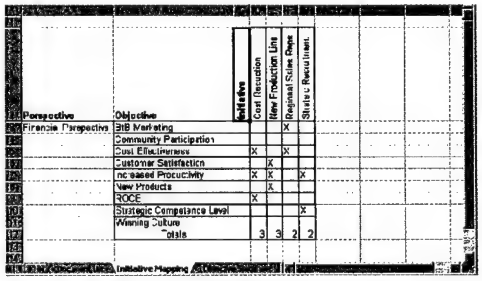
There is a common calendar and document library to keep your core team aligned to the process



The DC will produce the necessary documents based on work completed to date.

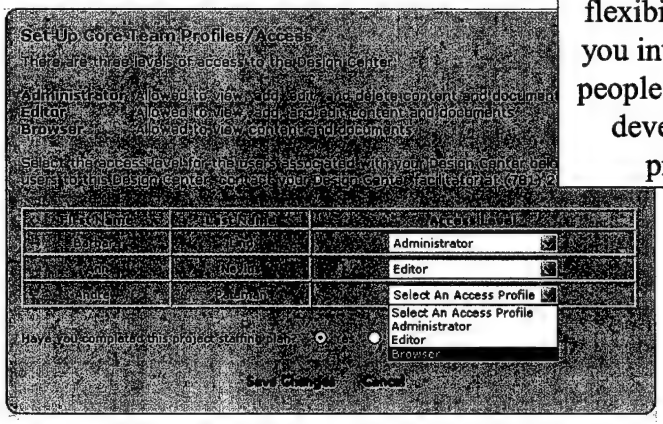


Customized documents created to support your workshops, team meetings, and implementation

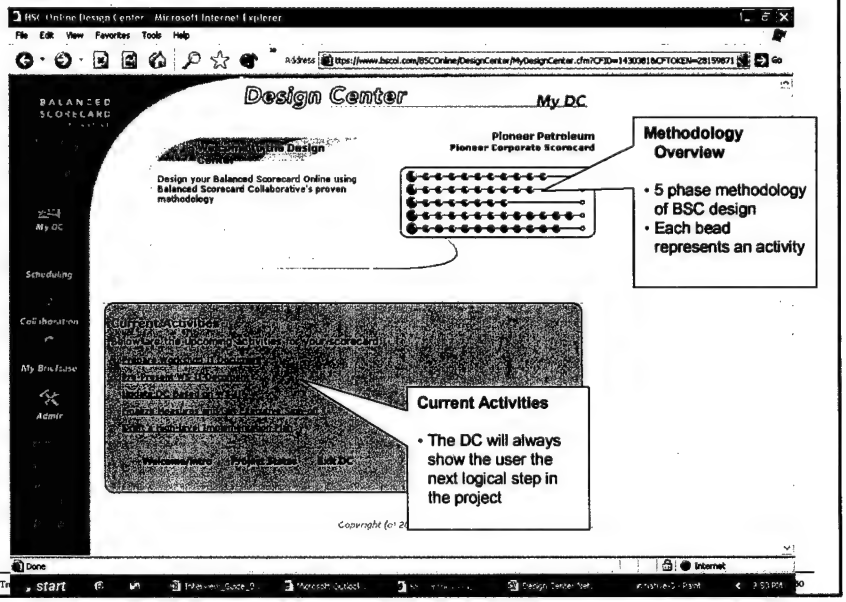


User-level access will allow for visibility in the project as well as control over the work

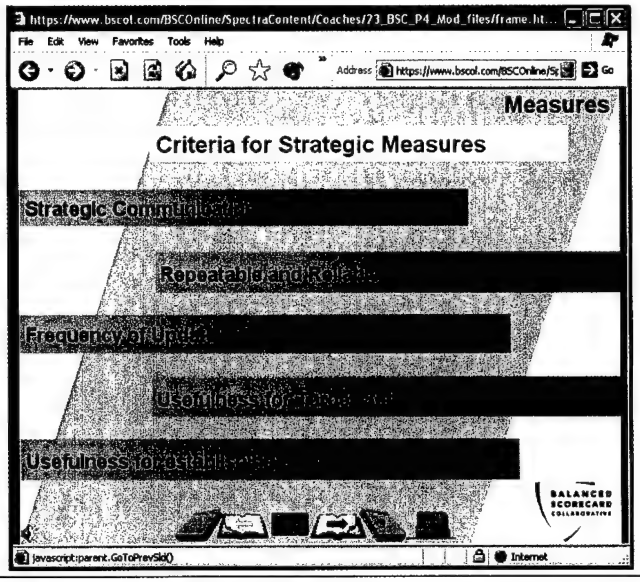
Access controls will allow greater flexibility and let you involve more people in the BSC development process



The user interface gives you a quick look at progress and one-touch access to the next step in the process

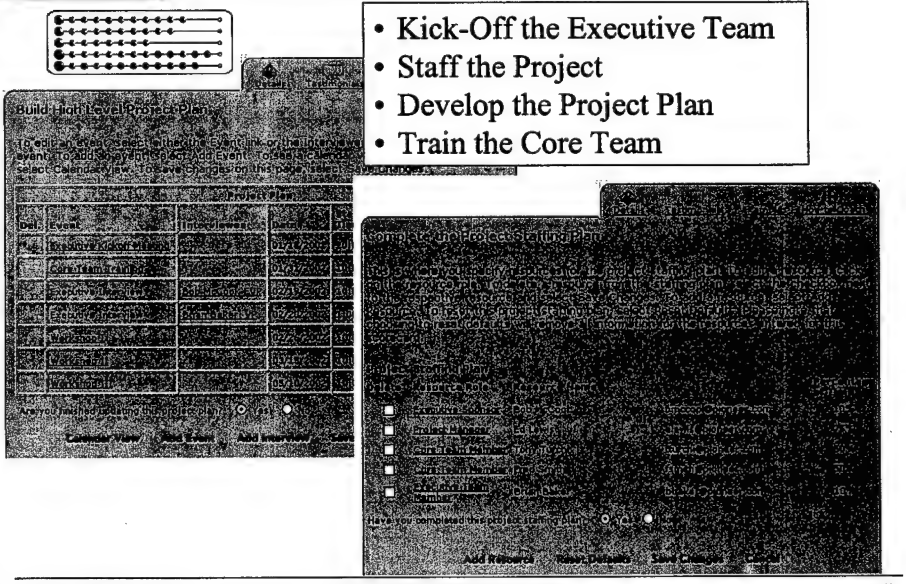


Over 30 multimedia coaches give you front line support at the time you need it



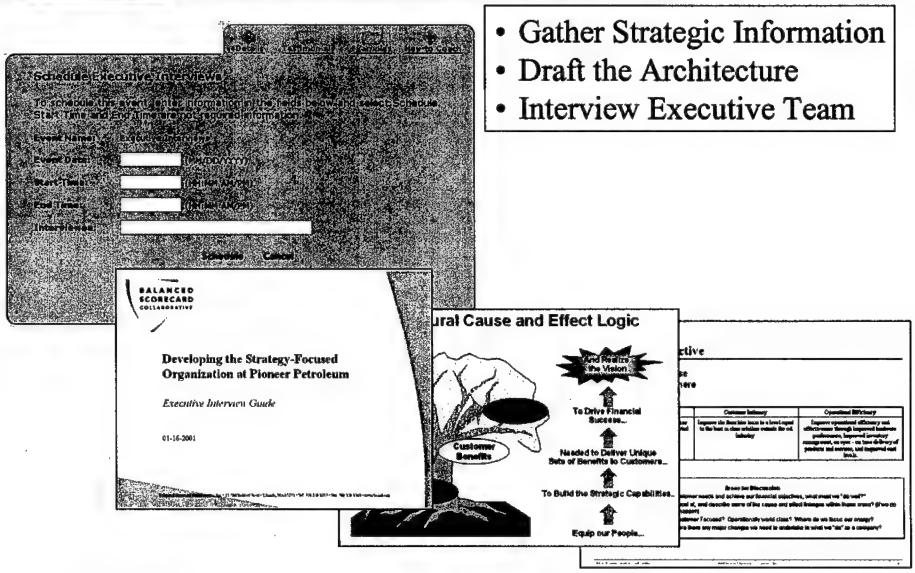
Phase 1: Launch the Process

- Kick-Off the Executive Team
- Staff the Project
- Develop the Project Plan
- Train the Core Team



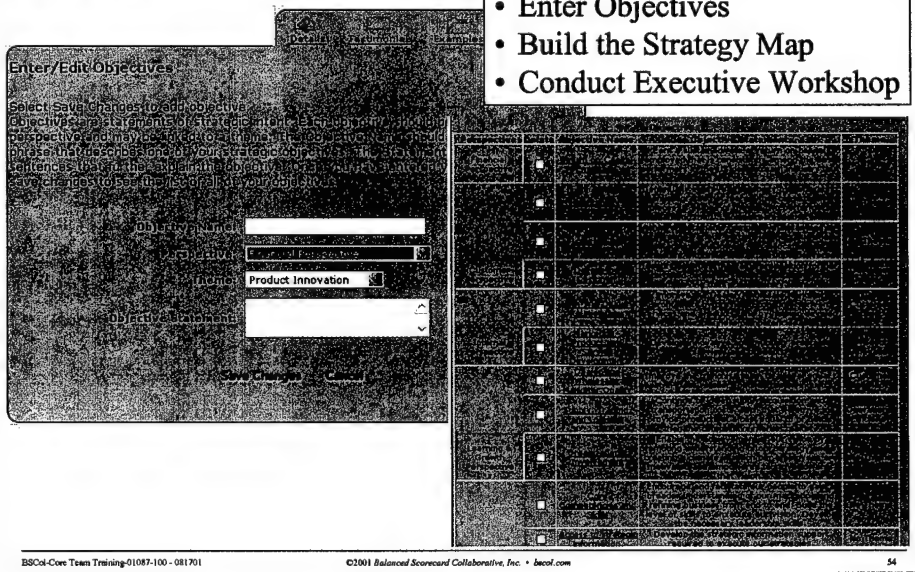
Phase 2: Scope out the Strategy

- Gather Strategic Information
- Draft the Architecture
- Interview Executive Team

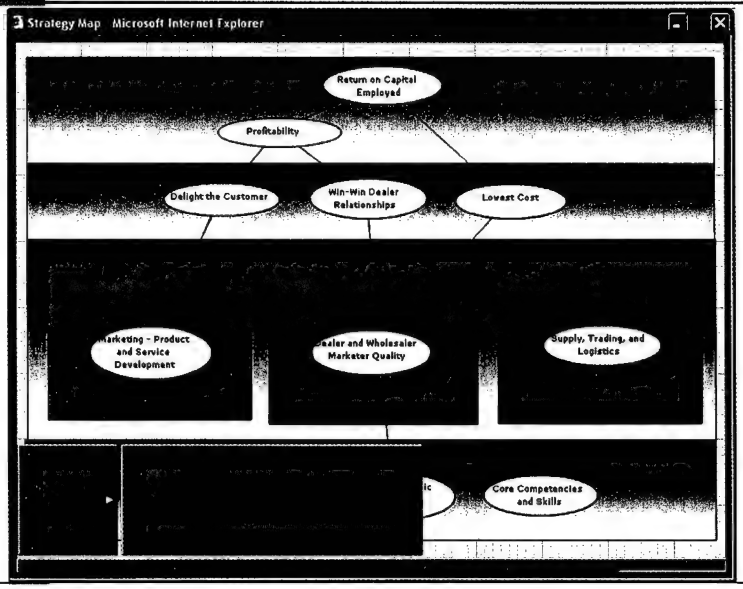


Phase 3: Map the Strategy

- Enter Objectives
- Build the Strategy Map
- Conduct Executive Workshop



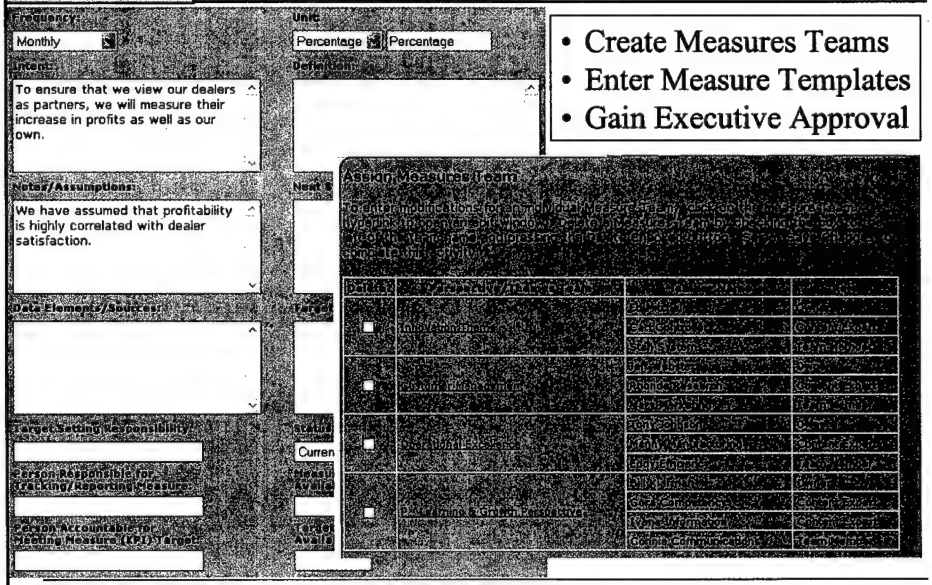
Phase 3: Map the Strategy



Step 4

Determine Measures and Targets

Phase 4: Identify Measures



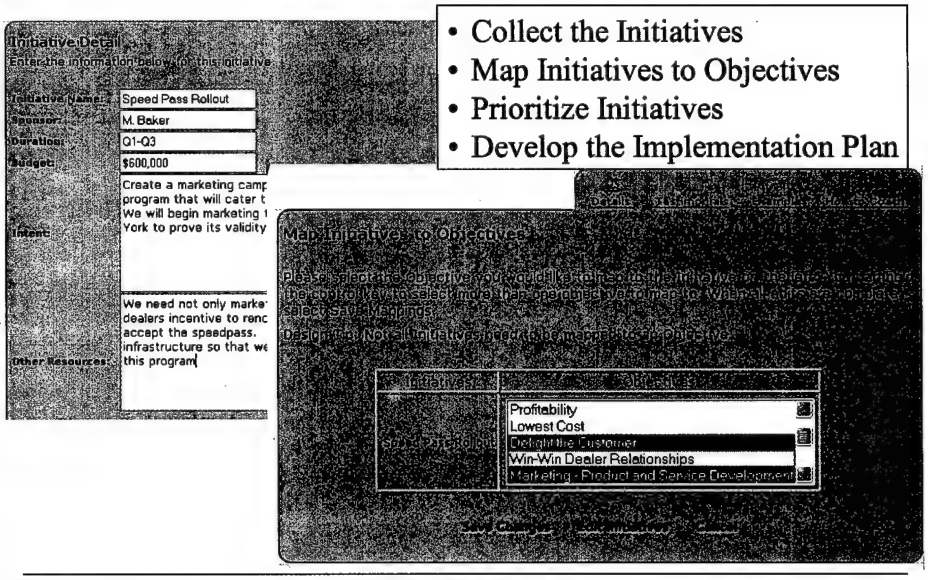
- Create Measures Teams
- Enter Measure Templates
- Gain Executive Approval

Step 5

Prioritize Initiatives and Plan to Implement

Phase 5: Plan the Actions

- Collect the Initiatives
- Map Initiatives to Objectives
- Prioritize Initiatives
- Develop the Implementation Plan

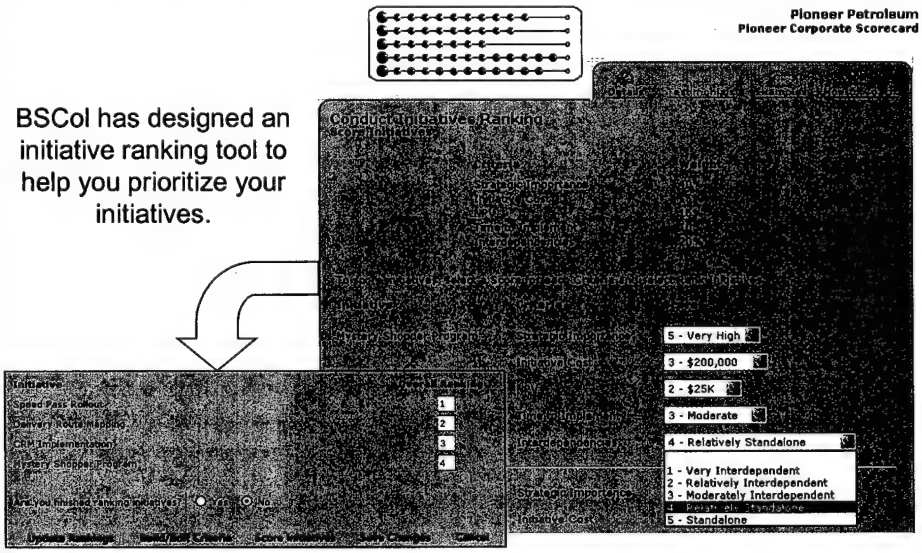


Step 5

Prioritize Initiatives and Plan to Implement

Phase 5: Plan the Actions

BSCol has designed an initiative ranking tool to help you prioritize your initiatives.

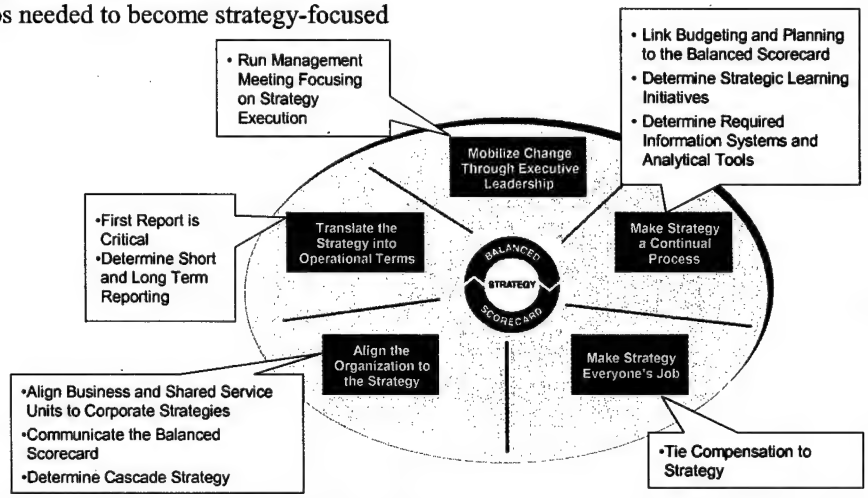


Step 5

Prioritize Initiatives and Plan to Implement

Phase 5: Plan the Actions

The implementation planning guide will help you lay out the short and long term steps needed to become strategy-focused



Next Steps for the Design Center

- Join BSC Online at www.bscol.com (Create your username and password)
- Ted will give you access to the Design Center
- Use the multimedia coaches to learn more about the process
- After you conduct your leadership interviews, post the notes to the Design Center

Core Team Training Agenda

The BSC Introduction (Concept and Development Process) – 90 minutes

The Design Center - 45 minutes

The Military Health System Architecture and Timeline - 15 minutes

Next Steps – 30 minutes

Military Health System Architecture

Stakeholder Perspective: Our stakeholders are the American people, expressed through the will of the President, Congress, and the Department of Defense

Customer Perspective: We have three customers, the active members of the forces, the beneficiaries to which we are entrusted, and the commands of the forces

Financial Perspective: We have a responsibility to our stakeholders to know what we are spending, have predictable budgets, and be within the appropriate range for public healthcare

Internal Perspective

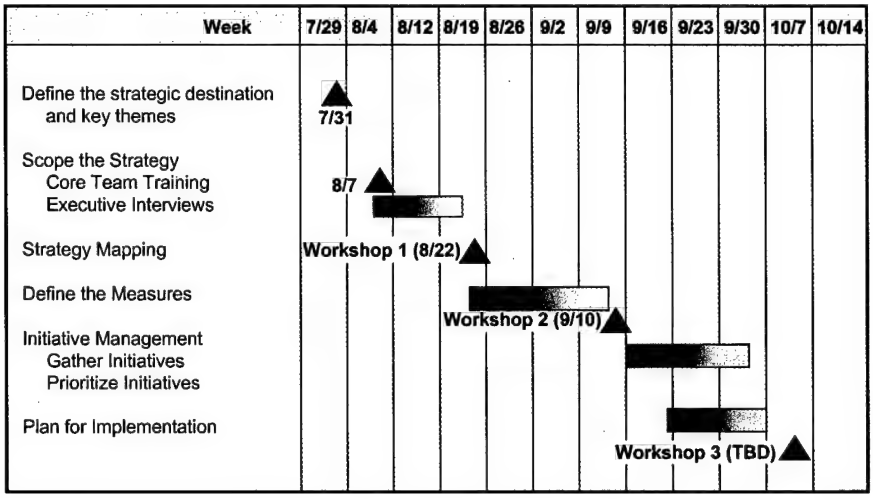
Readiness Theme
We must focus on the activities we need to do to ensure readiness of both our forces as well as the medical teams that support them.

Quality of Care Theme
We are responsible not only for the health of those entrusted to our care, but we must also ensure that we are world class at restorative care as well.

Operational Efficiency
We must be responsible stewards of the resources given to us, and we must work to continually increase the productivity of the system in which we operate.

Learning and Growth Perspective: Our people and our supporting IT infrastructure are critical to giving us the capabilities to execute on all we set out to achieve.

Military Health System Timeline for BSC Development



Core Team Training Agenda

The BSC Introduction (Concept and Development Process) – 90 minutes

The Design Center - 45 minutes

The Military Health System Architecture and Timeline - 15 minutes

➡ *Next Steps – 30 minutes*

Next Steps

- Sign up for BSC Online
- Become familiar with the BSC Online Design Center
- Agree to Leadership Interviews
- Post Interview summaries by August 14

Tab A, Appendix B

Appendix B
Tab A

Military Health System Interview Summary Template

Interviewer:
Interviewee:
Date:

Comments

What is our Strategic Destination:

Who are the Stakeholders:

Customer:

Financial:

Internal-Readiness:

Internal-Healthcare:

Internal-Operational Efficiency:

Learning and Growth (HR & IT):

Tab B, Appendix B

Appendix B
Tab B
Military Health System Interview Summary

Strategic Destination:

What is our Strategic Destination?

Interviewee3

Currently, we are providing episodic care, and in the future, we need to do a better job of maintaining the health of our population so that they are only visiting us (onsite) when they have real problems. This means that the traditional measures may not make sense. When people visit us, they might stay longer, and doctors might see less patients, but that is because we are dealing with real health issues.

In the future, the medics will be seen as an essential piece to war fighting, not as an afterthought. That means we must try to minimize the drag of providing care to our retirees so that the true benefits we provide in times of war are more visible.

We must increase the collaboration between the services and come to some agreement on standard deployable systems while still maintaining the identity of the services.

Interviewee1

We need to focus on the health of the overall population so that we can maximize the service time when individuals are "on-station." We need to ensure the people that we activate for duty have the capability to serve without interruption.

Interviewee6:

- There are two great benefits to implementing a BSC
  1. Produce better information
  2. Ensure Better accountability and responsibility
- Transformation
  1. Organization structure, governance, measures/metrics, and planning process
  2. Implement a new set of contracts (Healthcare and Operating Efficiency Theme)
  3. Ensure the Medical Readiness Platform (Direct Care System) is aligned with the transformation of the DoD (Readiness Theme)
  4. Reassess the benefits structure – ensuring that the costs, funding, etc are in-line with the benefits that the org delivers (Financial Perspective)

Interviewee8

What is the strategic destination for your organization? Win the Global War on Terrorism/Weapons of Mass Destruction, enhance joint warfighting and transform joint warfighting.

What will the MHS look like in 5 years? The MHS will be structured in a more integrated and joint way to meet the health care delivery and readiness missions. It will have modular and interoperable, capabilities based, deployable medical systems. It will have the capabilities and training necessary for medical response to weapons of mass destruction.

What are the major differences between where you are now and where you think you should be?
The MHS today is a composite of separate and distinct delivery and readiness systems. They must transform to a common operating picture with reduced variation. The MHS must transform to be able to deal effectively with medical response to WMD.
What needs to change? A way must be found to respect service unique requirements and foster integration.

Interviewee12

- We need to define MHS exactly what we mean by the term MHS.
- We will need a comprehensive compliance surveillance system with data to support
- Ability to collect data, have meaningful indicators on effectiveness of population health initiatives

Interviewee14

TMA needs to transition efficiently and effectively into T-NEX. The HA strategy will help to sharpen the focus of T-NEX. T-NEX is only one part of the HA strategy. Regional Governance, Population Health, and improved accountability are equally important.

What will the MHS look like in 5 years?

There will be more co-operation among the three services. Additional consolidation will eliminate the current situation where we have duplication (i.e. 3 types of mobile hospitals). Health care delivery platforms will be tri-service and there will be fewer military hospitals and clinics. The VA and MEDICARE will be more involved in health care delivery and graduate medical education. There will be greater reliance on the civilian sector and mixing and matching resources.

The major difference between then and where we are now is the process is currently personality dependent rather than based on policy or organizational structure. We need better definition of roles and authorities. The budget process needs to change to an activity based costing rather than the current incremental, short term process. His preference for governance is a medical command to identify and work the core business issues.

Interviewee13

- more difficult to be misunderstood if you are concise…we do two things: readiness and care…lose focus with multiple "ands"
- in general agree with these destinations
- interesting we are spending $27B and judging by 2 numbers…doesn't have the granularity we need but we can live with it

Interviewee9

We need an integrated healthcare delivery organization that supports the operational needs of our fighting forces. We should ensure that comprehensive healthcare and social support are available to families of active duty members. We cannot be all things to all people and need to focus our efforts and resources on the areas above.

Interviewee11

1. Integrator of service entities to provide effective and efficient healthcare and support readiness missions
2. Reduced HQ function, better resourcing, decent execution of services
3. Reduce un-necessary bureaucracy . We're too slow to respond to changes in the technical and financial aspects of healthcare.
4. Need to increase information to streamline business processes and adequately fund the benefit.

Interviewee2

-Key issue is operational support vs. peacetime/contractual support and maintaining a balanced system.
-tools to address imbalances are often unknown or unavailable
-future: smaller active (uniform) force, more robust contract support (providing care to the same population)
-focus on meeting the mission—form following function—what's important at the time
-future: only fine tuning needed, unless significant changes in the list of what we are told to do changes, or we are told to stop doing something

Interviewee4

- MHS is an organizational framework that respects the individuality of the Services and their medical departments, but rewards joint effort and cooperation for everyone's mutual benefit.
- The future will be heavily influenced by bio-terrorism threat and TFL
- Cost of caring for aging retiree population will put pressure on peacetime healthcare
- Readiness
    - Worst case: we will lapse into a lack of preparedness, especially for threat of bio-terrorism
    - Best case: improvement in protection against threats, better vaccinations (more effective and easier to administer). MHS is a leader in R&D efforts to improve bio-terrorism protection. Partner with industry.
- Need to pursue mutually beneficial joint efforts with VA
- MHS is the provider of choice for our beneficiaries
- How do we get there?
    - Peacetime: Need to use creative energy of our enterprise to engage our beneficiaries in the improvement of their health. We need to come up with ways to reward this creativity.
    - Wartime: We need to figure out what we can afford to give up in order to resource new priorities such as hem.-bio defense.

Interviewee5

- Believe, on second thought, that the drive toward HEDIS measures takes us too far into the weeds, and we should come back up to the 50,000 foot level
- The words we use in our mission and vision statements. Our destination should be a health organization, not a disease organization. Hard to measure this, and hard to do what we must to affect this change and reach this destination.
- TRICARE started as a "cost management" entity, not a "health management" one, and today we still have a primarily fiscal incentive system. This doesn't motivate doctors or

patients. We need other incentives that encourage those in the field to want to change their behaviors to affect the results we'd like.

- We need to measure what we say we want in our vision. This will re-define health on our terms.
- We are now picking up new tools—different tools. We're delivering health, not just healthcare, and our measurements are not adequate.

Interviewee10

Provide the American people a fit, healthy and protected military force capable of protecting and defending the nation at home and abroad.

Provide health services to all beneficiaries which are high quality, readily available, and effectively managed.

What will MHS look like in 5 years? Through collaboration, coordination and focused integration the MHS will advance toward a broader enterprise perspective for managing and executing the worldwide health services mission. It will possess a robust capability to respond to bio-terrorism and weapons of mass destruction. The DoD/VA partnership will be well established.

Interviewee7

- I'd like the destination as stated at our first meeting (in draft in package now).
- Significantly greater integration. Still 3 Service medical departments. I believe we'll have a medical command with a 4-star (line or medic). Significantly more military/civilian and DoD/VA partnering. Less robust military GME. More expensive than now. Much better optimized, effective and efficient. Primary care oriented.
- See previous question and answer"
- Minds. Hearts. Cultures. Structure and Processes.

Stakeholder:

Who are the Stakeholders?

Interviewee3

The soldier should come first in all of our thoughts. We must always be asking ourselves "Did anyone die that shouldn't have (or that could have been prevented)" Then, regardless of our stakeholders, we are fulfilling our mission

Interviewee1

The reserves do not get much funding directly from defense, and we need to be careful to ensure that reserves are counted as a part of the total force.
The stakeholders are focused on our ability to mobilize quickly and effectively, and the reserves want to know that they are going to have a nice quality of life (being taken care of), which will ultimately affect recruiting and retention

Interviewee8

Can you boil this list down to one direct stakeholder? Department of Defense
What does this stakeholder demand from you? That we be both effective and efficient in providing services and fighting war.
How do you know you are satisfying them? We know when they understand that the MHS has struck the correct balance between readiness and service delivery.

Interviewee6:

- DoD is the true stakeholder. The others (People, President, and Congress) are all represented in the vision of the DoD

Interviewee12

- Agreed with Sec Def as Stakeholder but does not believe it can be limited to one
  - Congress = laws
  - President = presidential orders
  - Sec Def = policy and implementing instructions
- Tradeoff between benefit and cost – we don't have this in place now; are unable to define it.
- Stakeholder satisfaction is expressed through public opinion, laws and management direction

Interviewee14

It is too simple to say that the DOD is our only stakeholder. On an ongoing basis Congress is probably the dominant stakeholder. Their demands are expressed as "free, perfect and now." DOD/HA has to respond to any perceived imperfection and remedy the situation immediately and hopeful with minimum or no cost. The lack of complaints or decrease requirement for meetings indicates that we are satisfying our stakeholders. From a political perspective the expectation is to provide the benefit even in the absence of additional funding. That is not realistic in a business environment or with a balanced budget.

Interviewee13

- DoD has richer benefit than the UAW…inappropriate?, not necessarily when viewed as part of a total compensation package…may be totally appropriate compensation when subjected to a critical analysis…key to look at employment-based risks which are higher for military than others.
- Important to recognize it is a rich benefit.
- DoD community demands CONUS quality medicine at OCONUS in all circumstances
- American People demand protection of their interests in whatever that takes.
- Concerned we have spent less intellectual energy on what is readiness…we are using old models
  - Previous models of casualty flow with updated inputs
  - Need to spend more time defining the medical support for OCONUS

Interviewee9

I would agree that the American people are primary stakeholders. However, our primary stakeholders are really DoD and our war fighters who depend upon us for care. Our system resource requirements should be focused upon the needs of our war fighters and their families.

Interviewee11

1.The Will of the President
2.Congress
3.Commanders
4.National Command Authority
5.Parents of our sons and daughters in uniform
6.Servicemembers and their families

Interviewee2

-Principal stakeholder: American citizen (but no direct input)
-DoD derives its role as a stakeholder from the citizen through voting and delegation
-DoD derives its authority from the president, and is our most direct source on interest, instruction, and responsibility
-DoD more and agent than just a stakeholder—has responsibility to and for MHS
-key stakeholder demands protection and maintenance of our way of life
-DoD demands we provide a fit and healthy force to accomplish the mission (population health), and medical support of the troops as they move forward (protect and repair health)
-Satisfaction for both = transparency
—no change in one's life-maintenance, deterrence, quick resolution
--mission not degraded or compromised

Interviewee4

- Need to capture in the Vision Statement the notion articulated in Stakeholder Perspective that we "accountable to the American people."
- Stakeholders should include the service members.
- Perhaps our only stakeholder is the service members. Interviewee4 said, "If we are doing our job with our people, everything else will fall into place."
  - For example, care for our retirees builds trust in our service members (fulfilled promise), helps in recruitment, and contributes to physician training.

- Our stakeholders demand world class healthcare for themselves and their families in peacetime and the comfort in knowing that when they are deployed, their families will be cared for.

Interviewee5

- No, we can't boil down this list of stakeholders.
- We'll know we're doing the right thing by them when we develop the right metrics to drive the behavior we want.

Interviewee10

Can you boil this down to one direct stakeholder: the American People
What does the stakeholder demand from you? That we ensure America's military is ready and able to defend and protect the nation from all adversaries.
How do you know you are satisfying them? When Congress and the Department believe that the MHS is effectively protecting, sustaining and restoring the health of our service members deployed and in garrison, and providing the promised benefit to their family members and retires.

Interviewee7

- Department of Defense
- A healthy and fit force that can successfully propagate America's wars. Timely and capable care of our wounded and ill. Quality prevention and intervention for our active duty families.
- Through an appropriate set of measures that focus (?) on their "hot buttons"—usually a healthy balance between delivery of the benefit and cost.

Customer:

Who are the customers?

Interviewee6

- Customer segments are accurate
- Overall grade would be a B
- Readiness we would get an A
- Service issues would be a B, but this is a dramatic improvement over 3-4 years ago

Interviewee3:

Interviewee3 agrees with the customers outlined in the architecture and thinks the priority should be on active duty members.
We need to have active engagement of our customers (the whole population). This engagement will help us proactively provide health services.
Our current ratings would be OK among active members, and we have a lot of work to do for the entire population.

Interviewee1

Our customers are the members of the armed forces, and we should prioritize our activities on the military members (rather than families and retirees). We need to improve the responsiveness of TriCare (although it is better than before). We also need to improve the education around using the military health system. Many reservist maintain their current health plans when they are activated to keep the continuity of care.

Interviewee8

Is there a shared view of customer segmentation? There are distinctly split views in our organization about the prioritization of customers but not the segmentation. Are these our customers? Yes
Is one customer group more important than the other? Yes. The active duty member is our raison d'etre.
What would a satisfied customer look like? Healthy, ready to deploy.
Key things our customers want from us? Quality services delivered in a timely and friendly fashion.
How do we know that we are delivering? They do not use the advocates we have when our system fails. They do not have to rely on individual knowledge of they system and work-arounds.
Is there a chance someone else…? Yes for portions of their needs. Their needs are not unitary.
What would happen…? External events. How would that affect us? Could impair readiness.
The Department of Defense? Not as ready – not as mission capable.
Are there future needs…? We don't know what we don't know about the future.

Interviewee12

- We should use the term "armed forces" instead of "active members of the forces"
- Real customers are the CINCs and Services. The other three (active members, beneficiaries, commands are agents for accomplishing satisfying the CINCs
- We don't have the metrics to determine if we are meeting the customer's expeditions

- The MHS is the only one who can meet the medical readiness needs of the CINCs

Interviewee14

In terms of values, the customers first recognize the quality of the benefit. Readiness is relevant to the active duty customers. Operational efficiency is expected from the commands. Customers should include our providers at all levels- from technical assistants to credential providers. All our customers are important but our beneficiaries are most important. A satisfied customer wants easily accessible, quality health care at an affordable price (i.e. free). A satisfied customer is evident in survey results, enrollment/disenrollment numbers and in changes in behavior that reflect trust (i.e. using phone or e-mail to contact provider rather than being seen in a clinic/ER). Except for deployment medical/surgical needs the civilian sector could serve our customers. To cause that change beneficiaries would have to elect to leave the MHS in large numbers. The elimination of the OB NAS could make that happen. For DOD costs would increase as dollars would go outside of the MHS and the loss of patients would result in closure or downsizing of MTF's and loss of GME programs. Also for our healthcare personnel training would suffer and quality of life as the fewer numbers would have to go on more deployments.

Interviewee13

- Do the increasing cost of the care mission impact the readiness mission…we don't know much about this…from the personnel perspective the HC mission is important to readiness
- Commands are constrained in their unconstrained mindset…about to get scrubbed…less about money than about bodies
- not subjecting government to the efficiency test like business has been through the past 20 year.
- Is stakeholder and customer the same…in most business it is hard to distinguish the two
- from my perspective the "folks in uniform in harms way" are most important…which is why our lack of attention to the readiness issue is so vivid to me
- should be looking at individuals medically ready (only community to have done this is dental) and medical units ready to deploy
- YES someone else could do our job…would happen as manpower goes to line
  - Tooth to tail transformation from SECDEF level…"can you outsource?"
  - Reaction to this by Chiefs of Staffs…more management oriented on how do we restructure for higher ops tempo.

Interviewee9

I agree with the customer statement offered, but would reemphasize that the MHS is in business to serve Active Duty forces and their families. These are our most important customers. Other customers are not necessarily less important, but it is possible that sources of care other than the MHS might meet the needs of some of those customers, provided that the alternative system is able to deliver a reliable, high quality standard of care.

Interviewee11

1. Our most important customer is our service members and their nuclear families
2. A satisfied customer is healthy, has easy access to our system in which the business processes are transparent to the customer and we have earned his trust and confidence in the quality of care that he receives.

3. Future needs that we must focus on are better analysis of informatics and such technologies as genomics that will give us greater insight on how to improve performance.

Interviewee2

-customer defined by people or groups being served—these are the right groups
--others are minor customers—congress, taxpayers, etc.
-Commander is primary customer—mission completion
--must meet the needs of the other customers (service members and beneficiaries)to meet primary customers needs
--know they will be care for, and their family will be cared for
-satisfied customer—force prepared, trained and equipped
--doesn't think about medical aspects
--if illness or injury—return to duty
--best healthcare possible under the circumstances
--needs key advice about medical needs—judged on how well he takes care of his troops health and welfare
--helped to manage risk in operational environment—right risk, right resources
-portion of needs could be met elsewhere
--technical needs may be met (possibly while deployed, but could not count on this)
--contract support lacks operational and military cultural perspective
--lack of tangible commitment to same goals
--who would the contract physician identify with as primary customer—patient or commander
--lack of operational perspective (military environment)—vaccine use, deployment stress, fit force, operational relevance (special ops, undersea, aerospace, PRP, etc)
---areas of need where future focus may decrease—GME (value to meet requirements) and over 65 care

Interviewee4

- Suggest rewording statement: "We have three customers, the active members of the forces, our beneficiaries whose care has been entrusted to us, and the commands of the forces."
- Value proposition is access and quality. It is not cost (i.e. free healthcare is not the value proposition).
- All customers are important. Once again she said, "If we are doing our job with our people, everything else will fall into place."
- We must measure customer satisfaction with disciplined, quantitative tools and processes. May include utilization rates and enrollment/disenrollment rates.
- Need defensible information. "Don't kid yourself [that you are doing a good job]."
- In the future we may be able to shift effort away from certain needs because science and technology either removes the need or supports safe and effective self-care.

Interviewee5

- Ultimately, most patient satisfaction is derived…derived from the nature of the services we provide them (the direct beneficiary).
- We'll know they're satisfied when we can deliver a healthy, fit force; force health protection becomes our banner.

Interviewee10

Is there customer segmentation? The segmentation relates more to prioritization of MHS customers. Are these our customers? Yes

All customers are important, however to protect, sustain and restore the health of the active duty service members is the primary mission and of utmost importance to our stakeholder.

What would a satisfied customer look like? A fit and healthy service member ready to deploy, knowing that family members will receive the best health services available while they are away.

What do our customers want from us? High quality heath care services readily available when needed.

How do we know we are delivering? Readiness of the force and health of the force when deployed. Customer satisfaction obtained through surveys, unit/command and congressional feedback.

Is there a chance someone else could satisfy the need? Yes, in some instance. However there are needs, such as operational and deployment health services that can only be reliably performed by DoD.

Interviewee7

- Yes. Emphasis has always been appropriately placed on the active duty member.
- Our customers want to get into our system when they need us, be well taken care of, and be able to do their jobs. Unhindered by physical or mental constraints. Appropriate clinical and administrative metrics and well-constructed surveys can tell us how we're doing it.
- Because of our unique operational requirements, uniformed medical personnel must deliver our core. "Others" can assist the military members in determined ways.

Doubt it. I see our needs expanding, not contracting.

Financial:

What are the financial considerations?

Interviewee3

We should focus on our entire resources, not just the finances. We usually get a budget authorization as well as a personnel authorization, so we do not always have the flexibility to resource projects according to our needs. A large value-add is our ability to influence "End-strength"

Interviewee1

Our ability to deliver peacetime healthcare is competitive with the private sector, and we need to be able to separate out readiness costs from this. The healthcare system for the forces could be combined and run by a purple suit (one surgeon general). This would help create some efficiency. The care you give to someone who has been shot should be the same across services.

Interviewee8

Do you have a target…? Yes Want it to grow? As appropriate.
What about your spending levels per person for healthcare? It will be higher than the civilian norm. Do you know what that is? Not with specificity.
What are the sources of money for your organization? The federal government through 2 distinct revenue streams. How is the number set? Through the PPBS cycle.
Are there any opportunities for getting revenue from other sources: Minimal.
How would you measure progress? That would depend on what progress meant. If it means fiscal efficiency then we would need a related efficiency measure. If we mean is the system fully funded then we would need a measure related to the number of customers. Future? Yes
Is there too much focus on cost management in this financial model? Only if it focuses on efficiency to the exclusion of effectiveness.
What could change that would cause a major difference? Change in mission, outsourcing of MHS functions, interagency shift of programs.

Interviewee12

- We are not always able to completely identify our budgets
- Spending levels per beneficiary don't matter; we should be basing success on outcomes (% with positive outcomes at X cost)
- We need financially accountability and the right measures
- A future change that would cause a major difference in our finances would be if veterans didn't have to prove service related disabilities

Interviewee14

Financial goals for MHS are all good as stated. I have a target for my budget and I want to see it grow to reflect inflation and growth I the private sector. Spending per person for healthcare in DOD is difficult to determine. We know eligibles and we know users but you can elect into the system at any time. Third party collections are another source of money. Amount is determined by calculating a percent of what is assumed to be available. Money is potentially available from MEDICARE, the accrual fund and third party insurance.

Living with the budget and eventually activity based cost are the measures for progress in the finances. We need more focus on the financial model and at more levels in the organization. A decrease in budget or the addition of new benefits without additional funding would cause a major difference in the finances of today and the future.

Interviewee13

- (cost per bene) no, I've asked that question…study is somewhere, someone is working it…(quizzical tone)
- direct care system and purchased care system better than MTF and downtown terminology…broader and more accurate
- open question is which is more effective
- patients vote with their feet and we see some leaving.
- we have no financial measure of performance.
- this is an organization that makes policy by antedate, not by data

Interviewee9

I agree with the statement offered. Since I am primarily involved in policy issues, my level of awareness of budget is less detailed than for those more directly involved in operations. However, the organization could benefit from having budgetary issues be more visible to senior leaders. Cost management is just one aspect of the financial model needed for the MHS, and must be preceded by clear definition of mission requirements in order to permit appropriate application of cost-benefit analysis to the budgeting process.

Interviewee11

1. Our spending levels must be risk adjusted based upon our served population..
2. Out budget target must be realistically indexed to the civilian industry and we must be appropriately resourced to take care of our human resources. We need to be adjusted for our readiness missions (non-HMO)
3. There is not too much focus on cost management in this financial model.
4. There needs to be a recognition that there are certain unavoidable inefficiencies built into our system with a high turnover of in our population of patients and providers due to contingencies, mobilization/demob.

Interviewee2

-"what" should refer to not only the what, but also the for what (accountability)—clarify wording
-predictable to objectively or rationally derived budgets
-appropriate range for public health doesn't include any cost for readiness
-capitation drives living within a system (HMO)—Leary of this—too often a cost or service limiting strategy
  --imperfect ways of measuring performance
  --efficiency index, not health index (?RVU)/person
-money sources—budget DHP, line WRM; other health insurance, ? accrual fund, grants/research
-expand research/grant opportunities and 3rd party billing
-how do you define "progress" related to finance--? Resource management
  --matching resources to requirements
  --progress visible in predictability—no supplemental
-there is a significant focus—not good at matching resources to requirements

--lack of proper priorities
-major change in resourcing—redirecting focus to direct care system—purchase care as a supplement to direct care system
--flexibility to cover for deployment costs may cause increase in civilian care costs (lack of predictability will increase contract costs)

Interviewee4

- Not clear in the statement what is meant by "and be within the appropriate range for public healthcare."
- Statement doesn't address relationship of spending to requirements.
- Need a process for rational prioritization of requirements.
- Current funding seems about right. "Feels like we have money in the bank."
- Need to improve effectiveness within current funding levels.
- Question weather spending levels per person is a meaningful measure.
    - Readiness vs. direct care
- Prevention is a potential opportunity for additional revenue.
- Our system should not/does not focus on cost. Instead, we should and do focus first on care.

Interviewee10

Do we have a target for your budget? Yes. Do you want it to grow: There are validated requirements which are not being met, which could be satisfied with additional funding.
What are the sources of money for your organization? DHP through the Defense appropriation.
How is this number set? Through the PPBS process.
Are there opportunities for getting funding from other sources: No, however there are opportunities to cost share to reduce direct costs. Such as partnering with the VA to increase volume and lower per unit or service cost.
How would you measure progress by looking at your finances today? Linking funding to delivery of specific products or services.
Is there too much focus on cost management in this financial model? No.
What could change that would cause a major difference in your finances of today and in the future? Change in mission requirements, reduction in military health care infrastructure, outsourcing of health services, new legislation on federal regulations.

Interviewee7

- We do have a target based on the PPBS cycle and the POM. I don't want it to grow, but it will.
- I don't
- Two separate appropriations. The number is set in the POM.
- Limited at this time, but it's time to become more entrepreneurial.
- Would look at the spend plan and business plan. Probably will be the same in the future.
- No, and it's balanced by our clinical management measures.
- It already happened on 11 Sep 01. We are now doing business as a military, totally differently than we did on 10 Sep 01. OPSTempo and PERSTempo are way up; the cost of fighting terrorism is way up; the use of the Guard and Reserve is way up. Costs of support for these new efforts can only go up.

Internal-Readiness:

What should be our focus on readiness as it relates to internal processes?

Interviewee3

We should focus on the readiness of our medical teams and their planning approach, technology, and flexible deployment. We are still deploying the way we did 10 years ago, and this needs to change.

Interviewee1

Reserves must focus on having updated screenings and fast mobilization (dental care for example must all be up to date)

We should also focus on the utilization of reservist medical teams. They should be prepared for battle, not doing checkups and screenings while they are doing their 39 days/year.

Interviewee12

- Under Readiness - " ....readiness of both our military forces as well as the medical assets that support them."
- When it comes to force health protection, the MHS needs to revolutionize
- We are not customer focused if you define the customer as the CINC
- The MHS needs to focus on being more joint
- We have always had the objectives to do joint operations, but have not been organized to achieve them
- Need to manage research dollars, medical doctrine and planning
- MHS needs to decide what is important
- MHS needs to develop indicators of health outcomes
- Human resource is the only one without regular maintenance

Interviewee13

- READINESS: people in uniform capable of doing the job they are assigned to do and deployable medical assets ready
- Where do we Focus: under invested intellectually in our readiness mission...may not have the assets to back up our words
- Where should we focus: readiness, we need a common vision/plan...what the AF calls Care in the Air the Army calls Die in the Sky...BG Green's AE concepts come close to a transforming plan but like the USMC is good for only 90 days...where is the rest of the plan for beyond 91?

Interviewee9

I agree with the statement offered. I feel that readiness is a product derivative of quality healthcare and operational efficiency.

Interviewee2

-themes in general correct—effectiveness or effectiveness and efficiency better than just efficiency alone
-system is innovative within the system—example AF readiness reengineering (evolutionary)
-these are the things we must do well

-we are customer sensitive, but need to better measuring
—often tend to be system centered and often concentrate on effects on system, money, turf, etc
-operationally world class
--deployed—yes
--peacetime healthcare benefit—globally yes with consistent size and quality of system, locally not necessarily at every location or with every procedure
-energy
--in the field—mission accomplishment then resources
--intermediate command—mission and resource balance with other aspects—politics and other players
--HQ—politics then resources then other areas and mission
---wasted energy—tension between TMA and Services, organizational structure discussions (purple suit, MEDCOM-current organization concept is good)—distract from productivity
-need to do—T-nex; clarification/realignment of governance, ensure proper uniform/civilian balance

Interviewee4

- These are the areas in which we must excel.
- We can make significant improvement in these areas through well managed evolutionary change.
- We are not innovators
- We are customer focused
- We are operationally world-class
- We should focus our energy on mission
    - Need to be creative while still focusing on mission

Interviewee5

- Believe we've already revolutionized our business when we stood up the concept of Force Health Protection. It turned things around.
- Also believe we'll have a technology revolution with web-based interactions. This is the first tool we've ever used that increases quality, increases satisfaction, decreases mistakes, and decreases cost!

Our other business practice changes are more evolutionary primarily through the process of optimization.

Interviewee10

Are these themes the right one? Yes
Are we hoping to revolutionize the MHS or just incrementally make it better/more effective? It is important to establish strategic objectives which will dramatically enhance the MHS for our customers and stakeholders, and then develop the incremental goals and objectives which are measurable and can serve as a guide to achieving the strategic objectives.
In order to meet our customer needs and achieve financial success, are these the things we must do well? Yes
Are we innovators? Customer focused....etc? We are innovators and we have a very creative and innovative MHS workforce, the more challenging the environment the more creative they become. We are working hard to enhance our customer focus both in the delivery of the benefit in the fixed facilities, in the purchased care network and in theater. We are the world leader in

protecting and providing health services for service members. We need to focus our energy on continual improvement and identifying opportunities to provide better service and support to service members, line commanders, family members and retirees.

Interviewee7

- Both!
- Yes!
- We must excel at them all. Access must be simple and patient-focused. Quality must be outstanding. Fiscal responsibility will drive greater optimization which can result in greater efficiency. Need to use a different adjective (not "operational") because operational has a very well-defined meaning in the military.
    - Innovators? Yes!
    - Customer-focused? Not nearly enough.
    - Operationally world-class? Absolutely!
- We focus on the mission and support of it, and that is completely appropriate and in no need of change.
- Yes! Governance for the contracts and <u>much</u> greater need for integration will drive a new look for our organization…and quickly. This is more "how" we do what we do, than change in what we do.
- Again, not in "what we do, but in "how" we do it.

Internal-Healthcare:

What should be our focus on quality as it relates to internal processes?

Interviewee3

We should focus on accurately recording and retrieving patient information over the life of care. This will allow us the ability to do better diagnostic and provide better lifetime care. It will also improve the quality of clinical information

Interviewee1

Interviewee1 noted that the quality of care was good, but the understanding of how to navigate the system and get the best use of the care needed improvement.

No real concerns about healthcare except that we need to do a better job of tracking and supporting reservist who get injured while activated. These people tend to get lost in the healthcare system.

Interviewee13

- HEALTHCARE: benefit to our beneficiaries that is competitive to anything else provided to the American people..the contract is to provide a good employee benefit
- Story: CNO reports retention is 85% for 1st timers…reason they reenlist is the health coverage
- Customer focused: NO…mainly lip service. We would not be losing market share if we were customer focused…NOT patient centered, unable to build trusting relationships
  - Practice like the rest of America
  - Rotate people too frequently (pt and staff) for bonding

Interviewee9

Quality healthcare supports and is necessary to readiness. However, I don't feel that this necessarily means that we need to be in the restorative care business (if we are in that business, I would grant that it should be world-class). Unfortunately, maintaining world-class restorative care may create diffusion of resources, since I view maintaining readiness and providing restorative care as two distinct businesses. This is an issue which needs to be addressed.

Interviewee2

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Internal-Operational Efficiency:

What should be our focus on efficiency as it relates to internal processes?

Interviewee3

We need to look closely at everything we do, and rather than try to "optimize" all of our activities, there may be certain activities that we decide not to do. We may want to get out of certain lines of business (such as doing particular surgical procedures in multiple locations). We could then refocus the freed up resources on optimizing remaining processes.

Interviewee1

The funding for reserves has not been addressed, and since they make up 40% of the population, and have been used much more frequently over the last 10 years, this is a strategic issue that should be addressed (Ted's note: I don't know if the issue is more prominent in the medical readiness and healthcare than it is for just traditional funding of the reserve services.) Given the extensive use of reserves, it begs the question, is there a more efficient means of establishing readiness.

Interviewee8

I would not call this operational efficiency because of the connotations of operational in the military culture. Operations and operational are what our operator bosses do. It is a term of military art that business has adapted as it adapted the staff model but the meanings are not the same.

We can talk about revolutionary change but in reality will incrementally change unless the overall military system undergoes revolutionary change.
These are the things we must do well.
What areas must we excel at – we must excel at them all. If "we" do these things well, then what will happen? – is an interestingly phrased question in that it brings up the question of WHAT we are – separate systems?, joint system? Something in between? Will require definition before any change will occur.
We are all of these things when viewed from some referent oint or another. We must focus our energy on our core mission.
The true change that we can undertake is organizational.

Interviewee14

We are trying for a major transformation in the MHS. We must excel at Force Health Protection and healthcare delivery for our beneficiaries. We need to get rid of the "old" work (examples not given). We are innovators and we have the right skills and knowledge. We are lacking in the organizational structure to execute the transformation and accomplish the mission.

Interviewee13

- Really a subset of the first two strategic themes and is more how we do them
- DoD plan goes to 05-09 POM so will see some change in the 05 budget in 04 but Surgeons can be active in the margin and we can set the stage for that in 03

- Example: collective agreement and process for doing MTF budgets based upon productivity within the peace time functions of healthcare
  - Give to the MTF/CC incentives to recapture workload…stop leaks and get money to use in MTF
  - Give to the provider incentive to do more work with work related pay…productivity incentives would replace current proxies like boards, rank and time … more money for more productive practice
  - These ideas can be modeled in 03…get data and run some scenarios..this will help us get from generalities to specifics
- some would say money is an enabler…I quite firmly think if you want to get something done you can…it is a matter of priority

Interviewee9

I agree with the statement offered. To increase productivity, we have to eliminate redundancy, which may come about as a result of perceptions of Service-specific operational needs driving sometimes inefficient use of resources. We should review our mission and goals for executive agencies within the MHS (e.g. surveillance, preventive medicine), which have compartmentalized functions ongoing in separate Services, to ensure appropriate alignment of missions and improve efficiency. We definitely need a more collaborative approach to meeting manpower requirements for the MHS.

Interviewee11

1. lack of political will
2. administration longevity
3. service unique concerns
4. lack of trust
5. risk aversion

We need to decrease our decision cycle, improve our data accuracy, better harmonize the service requirements, improve interagency coordination/decision making, work the POM and Congressional processes better and perform better actuarial analysis.

We need a true strategic approach to IT integration. Need to re-engineer business processes to enable IT and analyze clinical data that will allow us to create an appropriate intervention.

Interviewee2

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Learning and Growth (HR & IT):

What system issues relating to our employee growth are key indicators to consider?

Interviewee3

The key here is to improve Sr. Leadership and collaboration across the forces.
We need to create a performance-focused culture with accountability.
In IT, the one place I would invest would be in getting the current systems to communicate with each other. This needs to happen before we invest in new technologies.

Interviewee1

Interviewee1 was very complimentary on the leadership and said the recent combination of Tricare and HA was a logical step and should contribute to a positive culture.
On the IT side, he said the DEERS system needed updating.

Interviewee8

I would describe the critical enablers as DOTMLPF – doctrine, organization, training, materiel, leadership, people and facilities. These are the traditional military requirements for sustainment of any policy or action.

Interviewee12

- We need better managers of information – transparent to user "data that meets their needs"
- Better communication between services
- Clarity of vision
    - Common understanding of system and each leaders role in it
    - MHS understanding of vision, roles and responsibilities of members of the MHS at all levels

Interviewee14

Our technology (IM/IT) is not keeping pace with the demands we are placing on our systems.

Interviewee13

- we need an organization that honors and values skill of people…it is less about pay and more about how they value their work
- an HR organization spends more time worrying about if the jobs are meaningful…MHS shows no sign of being an HR org.
- we have the protoplasm…this is an organization with good servant people committed to the services (+) but too many disparate sets of instructions that change too frequently and provide no reward for establishing a vision (-)
- I am quite hopeful if we can take some of the cultural artifacts off the table…example Title X…clear in the charter…SG responsible to HA for the money use and to the Line for the service provided
- Too much static and you don't pay attention to other things
- our huge advantage is that the vast majority of the folks we need to get the job done are on our payroll…not like others where Drs come and go

- the problems we face here are not dissimilar to what is seen in other organization
- on the road to some exciting times…must get to common mission…otherwise waste time
- long knives are out there…some think medical care is like cooks…that we can provide the service via contractors (example of friend who served in Kosovo and had base support functions provided by a civilian contractor)
- WE MUST MAKE THE CASE OF WHY WE ARE NOT LIKE COOKS.

Interviewee9

We need a more strategic view of the HR organization for the MHS. Unfortunately, we don't seem to have an overarching program at present. Rather, it is a fragmented program with ill-defined strategic goals, with too much tactical (near term) orientation. I do not feel that the MHS has the key skills and capabilities in the right place to make the necessary changes to bring about improvement. We need a MHS HR staff. We have innumerable cultural barriers to implementation of an effective program. I also see a disconnect between the MHS and operational forces in the application of manpower to maintaining readiness. We need more seamless integration of application of our assets in this area. We are often crisis-driven, and lack consistent HR programs and policies. We need to develop our HR organization more along corporate model lines.

I note that under "critical enablers for our company", we are missing any mention of people! Our personnel are our most important weapons system, and deserve at least the same level of attention as other weapon systems. Unfortunately, we often take our people for granted.

IT infrastructure today is inadequate. Effective management of the MHS demands comprehensive, real time information support. We need rapid improvement in this area.

Interviewee11

1. Agree that these are the critical enablers for our company.
2. Need to commit to excellence in both clinical and technical expertise. Need to develop our leaders with both business acumen and clinical expertise.
3. Need to school our leaders in evaluative clinical science applied to our demographics.
4. We need to recognize our changing demographics, i.e. develop a career track so that women can take time off to have babies and still come back and maintain a career.. We need to be mindful of the changing civilian industrial environment.
5. The supporting technology is not quite in place. We need to have a better interface between user and the science.

Interviewee2

-poor definition/articulation of enablers

--what do strategic skills and strategic awareness mean, no mention of financial management or managed care skill

-need appropriate training and leadership development—training, experience, and broad exposure

-key to understanding and honoring the importance of the military culture—problem if if civilian leadership does not understand the importance of military culture, or the impact if it is ignored

--same problem between services but to lesser degree

--doctrine drives culture

-supporting technology is only partially in place

--greatest failure of resources invested vs. capabilities derived

-- multiple delayed implementations

--greatest opportunity for progress

Interviewee4

- Critical enablers:
  - Not clear what is meant by "Strategic Skills"
  - Change "Leadership" to "Leadership Development"
  - Add "Organizational Development"
    - Need to develop the skills of teams working together to accomplish organizational goals.
- HR
  - We do a good job with training and professional development of military personnel
  - We do not do a good job with training and professional development of civilian personnel
  - Need to be careful not to contract out activities and skills that are critical to government operations
    - Should not get too reliant on contracts
    - Need to carefully identify things that are inherently government and allocate government HR to those activities.
    - Example: Tri-West partnership with VA should have been done by the government. There was no reason why we should have been reliant on the contractor to do that.
- Information Technology
  - Going in the right direction
  - Need to strike the right balance between central and local IT development
    - Centrally develop to support common requirements and business processes
    - Acknowledge that some requirements are locally unique
  - Cannot afford to squander resources (need to ensure our development efforts are producing the biggest benefit for the dollars invested).
  - May not be adequately resourced compared to industry.

Interviewee5

- Believe we have the abilities across the MHS, but all the skills are not; however these skills are obtainable and need to be made available.
- There is not better talent pool than the one that exists amongst our outstanding personnel.
- We come from a conscript culture where we obey the rules, even to the point of "malicious compliance" at times. Yet we've already made significant improvement in this area. "Self talk" is important and works.

Architecture

- Think we've got it about right.
- There are two hard parts:

  We need to turn to our markets and make them the/our? centerpiece.

We need to really understand what we're doing (or not doing) to change our incentives to get what we want. We need to give to the field the metrics and correct incentives we need to reach our goals. That's where the work is done.

Interviewee10

Describe the nature of the HR organization: Human resource management is an important challenge-with each service managing resources in accordance with service policy, while pursuing the delivery of equally outstanding health care service. Given the rapidly changing world of health care delivery and management, coupled with the DoD deployment/operational medicine mission a high performing well trained staff is a critical element to MHS organizational success

Are the key skills and capabilities in place to meet the challenge? Not in all areas.

Are there any cultural issues/barriers that need to be addressed? We must continue to identify opportunities to work together and employ common and integrated solutions to meet our HR challenges.

Is supporting technology in place: Supporting medical and information technology is not in place for all requirements. Is moving in the right direction. It is important that the technology investment decisions be based on approved mission requirements. To support common business practices and optimize investment it is important to pursue standard information and medical technology solutions for the MHS.

Interviewee7

- (Not sure I understand what this question means.)
- For the most part. What is needed is a cogent way to communicate/coordinate across venues.
- Culture is a real key!! There are different cultures between HA/TMA and the Services, among the Services themselves, and between the military and our civilian contractors and counterparts.
- I believe most of it is. That which may not be immediately available can most likely be obtained.

Architecture:

- The overall architecture seems quite good to me. Only slight changes need to be considered for change; i.e., changing the word "operational" to something else; defining our stakeholder more tightly (DoD).

Appendix C

L&G-1 Measure—Learning & Growth Perspective 19 SEP 02

Measure: % of R&D Projects appropriately tied to strategic objectives **Strategic Objective:** Leverage Science and Technology **Measurement Intent:** Indicate level of alignment between strategic objectives and allocation of R&D resources.	**Frequency of Update:** Annual (June) **Units of Measure:** Percentages

Measurement Definition/Formula: Percentage of Defense Technical Objectives reviewed by the ASBREM that align with MHS strategic objectives

Notes/Assumptions: • Must get data from Technical Area Review & Assessment Chairs	**Next Steps:** Obtain data from TARA chairs for previous year
Measurement Information Is: _?__ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** TARA Chairs, ASBREM

Source For and Approach to Setting Targets: Establish performance baseline. Subsequent targets--TBD

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** LTG Peake/Mr. Reardon	**Tracking / Reporting Responsibility:** Dr. Sal Cirone (FHP&R)	**Measure Availability: TBD** **Target Availability:** TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 25%**	**Close gap 33%**	**Close gap 50%**	**100%**

L&G-2 Measure—Learning & Growth Perspective
19 SEP 02

Measure: Fill rate for selected specialties **Strategic Objective: Recruit, retain and develop personnel** **Measurement Intent:** Measure how effectively we are filling billets essential to carrying out our mission	**Frequency of Update:** 3x/year (June, October, January) **Units of Measure:** Percentage of billets filled

Measurement Definition/Formula: # of fully trained personnel/# authorized billets for fully trained personnel

Notes/Assumptions: • Consider all Medical Corps specialties, selected representatives of all other Corps, and 1 enlisted technical specialty	**Next Steps:** Define targeted specialties and solicit end strength data from Services
Measurement Information Is: _x__ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** Service Personnel System (DMDC Report to Congress?)

Source For and Approach to Setting Targets: Target is 95% fill rate for each specialty

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Service SGs	**Tracking / Reporting Responsibility:** CAPT Smith	**Measure Availability:** TBD **Target Availability:** TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 25%**	**Close gap 33%**	**Close gap 50%**	**95%**

L&G-2 Measure—Learning & Growth Perspective
19 SEP 02

Measure: Employee Satisfaction Survey **Strategic Objective:** **Recruit, retain and develop personnel** **Measurement Intent**: To determine the relationship between level of employee satisfaction and retention.	**Frequency of Update: TBD** **Units of Measure: Score**

Measurement Definition/Formula: Satisfaction Score

Notes/Assumptions:	**Next Steps: See LG2 Initiatives worksheet**
Measurement Information Is: ___ Currently Available ___ Available With Minor Changes _X__ Not Available	**Data Elements and Sources: Survey Tool under development**

Source For and Approach to Setting Targets: Establish performance baseline. Subsequent targets--TBD

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Services	**Tracking / Reporting Responsibility:** Dr. Dick Guerin	**Measure Availability: TBD** **Target Availability:** TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.					

L&G-3 Measure—Learning & Growth Perspective 19 SEP 02

Measure: % of patient encounters documented in CHCS II **Strategic Objective: Patient/provider focused information systems which enhance capability** **Measurement Intent:** Measures utilization of CHCS II and progress toward full system implementation	**Frequency of Update:** Quarterly **Units of Measure:** Percent of encounters

Measurement Definition/Formula: # of patient encounters documented in CHCS II/ total # of MHS patient encounters

Notes/Assumptions: • All patient encounters are entered into either CHCS I or CHCS II	**Next Steps:** Validate the end to end methodology for constructing metric to ensure accuracy
Measurement Information Is: ___ Currently Available _x_ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** Military Health System Data Repository

Source For and Approach to Setting Targets: Five year target—100%

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** **MHSCIO** (Mr. Reardon)/Services	**Tracking / Reporting Responsibility:** COL Mark Lyford	**Measure Availability:** TBD **Target Availability: TBD**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 15%**	**Close gap 33%**	**Close gap 50%**	**100%**

L&G-3 Measure—Learning & Growth Perspective
19 SEP 02

Measure: TRICARE Online Usage **Strategic Objective:** Patient/provider-focused information systems which enhance capability **Measurement Intent:** Measures utilization of TRICARE Online (TOL)	**Frequency of Update:** Quarterly **Units of Measure:** Number of Appointments Made

Measurement Definition/Formula:
Number of Patient Appointments Made Via TRICARE Online Per Year

Notes/Assumptions:	**Next Steps:**

Measurement Information Is: __x_ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** Data from ADHOC Reports Available on TOL

Source For and Approach to Setting Targets: Five year target— 7.5 Million Appointments/Year

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** **MHS CIO (Mr. Reardon)/ Services**	**Tracking / Reporting Responsibility:** CAPT Brian Kelly and Service Reps	**Measure Availability:** Now **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	100,000 Appointments	1,000,000 Appointments	3,000,000 Appointments	5,000,000 Appointments	7,500,000 Appointments

L&G-4 Measure—Learning & Growth Perspective
19 SEP 02

Measure: # of unfilled DHP billets where other Service overages exist **Strategic Objective:** Enhance Jointness **Measurement Intent**: Optimize process by which personnel resources are assigned	**Frequency of Update:** 3x/year (June, October, January) **Units of Measure: Number** of positions by specialty

Measurement Definition/Formula: By specialty, # of billets below authorized end strength (by Service) with corresponding overages (by Service)

Notes/Assumptions: • Assumption: Operational billets excluded • Examine same selected specialties as examined under fill rate	**Next Steps:** Determine targeted specialties and solicit data from Services
Measurement Information Is: _x_ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** Service Personnel data system

Source For and Approach to Setting Targets: Establish internal baseline. Five year target: 0

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Service SGs	**Tracking / Reporting Responsibility:** CAPT Smith	**Measure Availability: TBD** **Target Availability:** TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 25%**	**Close gap 33%**	**Close gap 50%**	**0**

R-1 Measure—Internal Perspective: Readiness
19 SEP 02

Measure: Individual Medical Readiness (IMR) **Strategic Objective:** Provide a Medically Ready Total Force **Measurement Intent**: Monitor Individual Medical Readiness criteria as part of the overall effort to proactively monitor the deployability of the active-duty base force.	**Frequency of Update:** Quarterly **Units of Measure:** Percentage

Measurement Definition/Formula: # Of Personnel Meeting all IMR Requirements

Notes/Assumptions: **Inter-Service team determining components that are common to all the Services. Five initial criteria have been proposed (Immunizations, readiness labs, Dental class, deployment limiting conditions, and current assessment)**	**Next Steps:** Once basic criteria are established must develop/implement systems to gather the data and provide data interoperability. Further expansion of the criteria to include medical equipment and training should be explored

Measurement Information Is: ___ Currently Available __ Available With Minor Changes __X_ Not Available (Except AF)	**Data Elements and Sources:** Measurement to be developed

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Ms. Embrey, LTG Peak	**Tracking / Reporting Responsibility:** Col Cunningham	**Measure Availability: Now** **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	70% Adequate 40% Optimal	72% Adequate 45% Optimal	75% Adequate 50% Optimal	78% Adequate 55% Optimal	80% Adequate 60% Optimal

R-1 Measure—Internal Perspective: Readiness
19 SEP 02

Measure: % completeness individual database entries **Strategic Objective:** Provide a Medically Ready Total Force **Measurement Intent:** Monitor individual and population health events, with timely specific target population-focused analyses.	**Frequency of Update:** Quarterly **Units of Measure:** Percentage

Measurement Definition/Formula: % of total force personnel with timely complete data incorporated into the common DoD medical surveillance system.

Notes/Assumptions: Multiple Service-specific surveillance programs must integrate to give a complete and comprehensive DoD surveillance picture.	**Next Steps:** Specific DoD comprehensive medical surveillance requirements must be defined and agreed-upon by the Services. Then an integration plan developed and implemented.
Measurement Information Is: ___ Currently Available __ Available With Minor Changes __X_ Not Available	**Data Elements and Sources:** Individual medical event and health status data from various clinical sources must be integrated into a common surveillance data system for analysis.

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Ms. Embrey, LTG Peak	**Tracking / Reporting Responsibility:** Col Cunningham	**Measure Availability: TBD** **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	50%	60%	70%	80%	95%

R-2 Measure—Internal Perspective: Readiness
19 SEP 02

Measure: SORTS **Strategic Objective:** Provide a Ready Medical Capability **Measurement Intent:** The intent is to measure the percent of Tri-Service, OPLAN tasked, medical units reporting C1 or C2 in the Status of Resources and Training System (SORTS).	**Frequency of Update:** Quarterly **Units of Measure:** Percent

Measurement Definition/Formula: Total number of units with deployment taskings reporting C1 or C2 divided by the total number of units with deployment taskings

Notes/Assumptions: Assumption is that this will make all reporting classified consistent with OPLAN classified	**Next Steps:** Discuss at next meeting ELT plans for BSC metric presentation in CLASSIFIED, Secure setting for the SORTS reporting portion

Measurement Information Is: __x_ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** CLASSIFIED SORTS CODES from Services. Reporting of this information will require SIPRNET or Classified Net reporting of BSC metrics

Source For and Approach to Setting Targets: 85 percent of assets that are on-hand and ready to execute a deployment tasking

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Ms. Embrey, LTG Peak	**Tracking / Reporting Responsibility:** Col Cunningham	**Measure Availability: Now** **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	70%	73%	78%	81%	85%

R-2 Measure—Internal Perspective: Readiness
19 SEP 02

Measure: Define common core medical requirements for joint medical response operations, including related training, equipment and exercise standards **Strategic Objective:** Provide a Ready Medical Capability **Measurement Intent**: Percent of common core medical requirements defined for joint medical response operations, including training, equipment and exercise standards	**Frequency of Update:** Quarterly **Units of Measure:** Percent

Measurement Definition/Formula: Percent of common core medical requirements defined for joint medical response operations, including training, equipment and exercise standards

Notes/Assumptions: A common core set of medical requirements for joint medical response operations can be developed	**Next Steps:** Determine common core set of medical requirements for joint medical response operations

Measurement Information Is: ___ Currently Available ___ Available With Minor Changes __X_ Not Available	**Data Elements and Sources:**

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Ms. Embrey, LTG Peak	**Tracking / Reporting Responsibility:** Col Cunningham	**Measure Availability:** **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	20%	43%	60%	80%	95%

Q -1 Measure—Internal Perspective: Quality Theme 19 SEP 02

Measure: # of near misses (good catches) divided by total of near misses + actual events **Strategic Objective:** Improve Patient Safety **Measurement Intent**: Quantify near misses across the system and incentivize reporting of less serious events with potential to improve safety of system	**Frequency of Update: Quarterly** **Units of Measure: Percentage**

Measurement Definition/Formula: **# Near misses/Total of near misses plus actual events**

Notes/Assumptions: **Data collection has just begun, and database is incomplete. Events would be expected to rise, initially, as reporting compliance improves.**	**Next Steps:** Begin

Measurement Information Is: _x_ Currently Available __ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** Patient Safety Report from AFIP's Patient Safety Center

Source For and Approach to Setting Targets: Establish organizational performance. Subsequent targets--TBD

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Dr. Tornberg	**Tracking / Reporting Responsibility:** CAPT Stewart	**Measure Availability:** OCT 02 **Target Availability: TBD**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**TBD**	**TBD**	**TBD**	**Civilian Benchmark**

Q-2 Measure—Internal Perspective: Quality Theme 19 SEP 02

Measure: Satisfaction with Encounter **Strategic Objective:** Increase Patient-centered focus **Measurement Intent:** Measure level of satisfaction with Direct Care System encounter	**Frequency of Update:** Quarterly **Units of Measure:** Percentage

Measurement Definition/Formula: CSS #12—How satisfied were you with (specific clinic) during this visit? Will report % who are somewhat to completely satisfied, and report % who are completely satisfied

Notes/Assumptions:	**Next Steps:** Begin
Measurement Information Is: __x_ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** Customer Satisfaction Survey—TMA PA&E

Source For and Approach to Setting Targets: Somewhat to completely satisfied-90%; Completely satisfied—50%

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Dr. Tornberg	**Tracking / Reporting Responsibility:** PA&E—Dr. Guerin	**Measure Availability: Now** **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 25%**	**Close gap 33%**	**Close gap 50%**	**1. 50% highly satisfied with encounter. 2. 80th percentile of civilian plans for ease of access**

Q-2 Measure—Internal Perspective: Quality Theme
19 SEP 02

Measure: Satisfaction with Access **Strategic Objective:** Increase patient-centered focus **Measurement Intent:** Measure level of satisfaction with access to MHS	**Frequency of Update:** Quarterly **Units of Measure:** Percentages

Measurement Definition/Formula: 1) Percentage who had no problem getting needed care; 2) Percentage usually or always getting care quickly; 3) Percentage who found it easy to make an appt by phone in direct care system

Notes/Assumptions: • Items 1 and 2 will be measured across entire MHS • Item 3 will be direct care system only	**Next Steps:** Begin
Measurement Information Is: _x__ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** 1 & 2: Health Care Survey of DoD Beneficiaries; 3: Customer Satisfaction Survey

Source For and Approach to Setting Targets: 1 &2: Compare performance to 80th percentile for civilian plans
3: Establish internal standard with subsequent targets TBD

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Dr. Tornberg	**Tracking / Reporting Responsibility:** PA&E—Dr. Guerin	**Measure Availability: Now** **Target Availability:** 1&2, Now. 3, TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 25%**	**Close gap 33%**	**Close gap 50%**	**80th percentile of civilian plans**

Q-3 Measure—Internal Perspective: Quality Theme 19 SEP 02

Measure: Number of Preventable Admissions **Strategic Objective:** Improve Health Outcomes **Measurement Intent**: Assessment of quality of ambulatory and restorative care, and access to system	**Frequency of Update:** Quarterly **Units of Measure:** Number per 1000 population

Measurement Definition/Formula: Number of Direct Care system admissions/1000 population to be reported for 9 common diagnoses in our system (Asthma, Bacterial Pneumonia, COPD , Diabetes, Gastroenteritis, Congestive Heart Failure, Angina Pectoris, Urinary Tract Infections, and Cellulitis)

Notes/Assumptions: • Benchmark against high income standards • Measure Direct Care system	**Next Steps:** Begin
Measurement Information Is: __x_ Currently Available ___ Available With Minor Changes ___ Not Available	**Data Elements and Sources:** SIDR and HCSR (I)

Source For and Approach to Setting Targets: Benchmark against Civilian 80th percentile

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Dr. Tornberg	**Tracking / Reporting Responsibility:** PA&E—Dr. Guerin	**Measure Availability:** now **Target Availability:** date

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Establish Baseline**	**Close gap 25%**	**Close gap 33%**	**Close gap 50%**	**80th percentile of civilian plans**

E-1 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Improve Interoperability with Partners Measure: Value of DoD/VA Sharing Measurement Intent: Determine the monetary value of VA-DoD Joint Procurement Dollars	Frequency of Update: Yearly Units of Measure: Dollars

Measurement Definition/Formula: Formal agreements for transfer of funds between VA and DoD

Notes/Assumptions: Opportunities exist to increase monetary value of joint procurement	Next Steps: Determine targets of future joint procurement
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: Budget Data

Source For and Approach to Setting Targets: Recommendation from Executive Branch

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	CDR McDonald	Target: $100 M

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	$100 M	**TBD**	**TBD**	**TBD**	**TBD**

E-2: Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Enhance System Productivity Measure: RVU/FTE Measurement Intent: Focus on productivity of the patient care system	Frequency of Update: Quarterly Units of Measure: units

Measurement Definition/Formula: Number of Work Relative Value Unit visits per Full-time Equivalent (FTE) provider per 8-hour day in US military clinics.

Notes/Assumptions: Non-physician providers discounted by 0.75 per performance contract. Inpatient, provider productivity is measured as amount of Relative Weighted Product per FTE available provider. Outpatient, units of Relative Value Unit per FTE available provider.	Next Steps: Develop RWP/FTE targets Develop RVU/FTE for all specialties
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: FTE available providers, RVUs, RWP from M2. All Region Server (SADR) and EASIV

Source For and Approach to Setting Targets: 1 yr goal in USD Performance Contract. 5 yr goal recommended by core group.

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Bob Opsut	Target: = to or > 25

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**16**	**18**	**20**	**22**	**25**

E-2 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Enhance System Productivity Measure: Clinical availability of provider Measurement Intent: Focus on system productivity based on available providers of care.	Frequency of Update: Quarterly Units of Measure: FTE available to select MEPRS accounts/Total Assigned.

Measurement Definition/Formula: For outpatient, FTE available providers in MEPRS B Accounts/Assigned Providers. For inpatient, FTE available providers in MEPRS B Accounts/ Assigned Providers.

Notes/Assumptions: (1) can be higher than one due to borrowed labor. (2) Inpatient measure could be based on FTE RN availability. Assumption is that civilian care is always available.	Next Steps: Understand the constraints effecting provider availability and take steps to correct them.
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: M2 for all data in these two metrics. Original source is EAS-IV.

Source For and Approach to Setting Targets:

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Bob Opsut	Target: = to or > 80%

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**>70%**	**>73%**	**>75%**	**>77%**	**> 80%**

E-2 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Enhance System Productivity Measure: Hospital Occupancy Rate Measurement Intent: Focus on system efficiency based on occupied bed days.	Frequency of Update: Quarterly Units of Measure: Percent

Measurement Definition/Formula: Occupancy of staffed beds.

Notes/Assumptions: Consider work load management system as mechanism to define staffed bed	Next Steps: Develop mechanism to receive data

Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: All Region Server (SIDR, HCSR)

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	Accountability for Meeting Target: Mr Ford/Lt Gen Taylor	Tracking / Reporting Responsibility: Dr. Bob Opsut	Measure Availability: Target: = to or > 80%

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**>70%**	**>73%**	**>75%**	**>77%**	**> 80%**

E-2 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Enhance System Productivity Measure: Inpatient days/1000 Measurement Intent: Focus on inpatient usage.	Frequency of Update: Quarterly Units of Measure: Days

Measurement Definition/Formula: The number of bed days per 1000 enrollees in the direct care system

Notes/Assumptions: Inpatient days is a measure of how well MHS benchmarks with other managed care organizations	Next Steps: Measure days/1000 purchased care
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: All Region Server (SIDR,HCSR,DEERS)

Source For and Approach to Setting Targets: External Benchmarking

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Bob Opsut	Target: = or < 195

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**<250**	**<240%**	**<225**	**<210**	**<195**

E-2 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Enhance System Productivity Measure: Prime Leakage Measurement Intent: Determine private sector care (PSC) expenditures that occur for TRICARE Prime enrollees	Frequency of Update: Quarterly Units of Measure: Percent

Measurement Definition/Formula: Percent of private sector care cost is incurred by MTF enrolled population, within the market area of facility, for services which could be performed within facility.

Notes/Assumptions: The percent contribution made by MTF enrollee's to the total cost of prime private sector care, for care which could be provided in the direct care setting.	Next Steps: Begin collecting data
Measurement Information Is: ___ Currently Available _X__ Available With Minor Changes	Data Elements and Sources: Numerator: Cost of outpatient private sector care services for MTF enrollees within Market Area for services, which MTF has performed during preceding year. Denominator: Total Cost of outpatient private sector care for MTF enrollees within Market Area

Source For and Approach to Setting Targets: Internal benchmarking

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Bob Opsut	Target: = to or < 30%

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**<40%**	**<37%**	**<35%**	**<32%**	**<30%**

E-2 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Enhance System Productivity Measure: Cost per RVU Measurement Intent: Focus on productivity of the patient care system	Frequency of Update: Quarterly Units of Measure: Dollars

Measurement Definition/Formula: Cost/RVU

Notes/Assumptions: Calculating the cost per RVU will permit improvements in cost efficiency.	Next Steps: Develop methodology and monitor cost of both direct and private sector care for MTF enrollees
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: FTE available providers, RVUs, RWP from M2. All Region Server (SADR) and EASIV

Source For and Approach to Setting Targets: 1 yr goal in USD Performance Contract. 5 yr goal recommended by core group.

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Bob Opsut	Target: TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**TBD**	**TBD**	**TBD**	**TBD**	**TBD**

E-3 Measure-Internal Perspective: Efficiency Theme
19 SEP 02

Strategic Objective: Identify and Prioritize Requirements Measure: Completion of PA&E Study Measurement Intent: MHS Total asset visibility	Frequency of Update: TBD Units of Measure: Percent of justified readiness requirements

Measurement Definition/Formula: Percent of staffed and funded readiness requirements

Notes/Assumptions: Requirements will be available from PA&E results.	Next Steps: Determine actions based on PA&E results
Measurement Information Is: ___ Currently Available ___ Available With Minor Changes	Data Elements and Sources: Personnel requirements from PA&E

Source For and Approach to Setting Targets: Execute defined readiness requirement

Target Setting Responsibility: Mr Ford/Lt Gen Taylor	Accountability for Meeting Target: Mr Ford/Lt Gen Taylor	Tracking / Reporting Responsibility: Mr Ford/Lt Gen Taylor	Measure Availability: Target: 15 Nov 02

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**100%**	**100%**	**100%**	**100%**	**100%**

C-1 Measure—External Customer Perspective
19 SEP 02

Measure: Individual Medical Readiness (IMR) **Strategic Objective:** Deliver fit, healthy and medically protected force **Measurement Intent:** Monitor Individual Medical Readiness criteria as part of the overall effort to proactively monitor the deployability of the active-duty base force.	**Frequency of Update:** Quarterly **Units of Measure:** Percentage

Measurement Definition/Formula: # Of Personnel Meeting all IMR Requirements

Notes/Assumptions: **Inter-Service team determining components that are common to all the Services. Five initial criteria have been proposed (Immunizations, readiness labs, Dental class, deployment limiting conditions, and current assessment)**	**Next Steps:** Once basic criteria are established must develop/implement systems to gather the data and provide data interoperability. Further expansion of the criteria to include medical equipment and training should be explored

Measurement Information Is: ___ Currently Available __ Available With Minor Changes __X_ Not Available (Except AF)	**Data Elements and Sources:** Measurement to be developed

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	**Accountability for Meeting Measure (KPI) Target:** Mr. Spruell/RADM Carrato	**Tracking / Reporting Responsibility:**	**Measure Availability: Now** **Target Availability:**

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	70% Adequate 40% Optimal	72% Adequate 45% Optimal	75% Adequate 50% Optimal	78% Adequate 55% Optimal	80% Adequate 60% Optimal

C-2 Measure—External Customer Perspective
19 Sep 02

Strategic Objective: Deliver high quality care anywhere Measure: Industry-Based Quality Outcome Measures Measurement Intent: Establish an index to measure quality outcomes. Each metric is a stand-alone indicator	Frequency of Update: Quarterly Units of Measure: Number of Measures Met

Measurement Definition/Formula: The index comprises nine distinct indicators, each with their own target/goal. See attached

Notes/Assumptions:	Next Steps:
Measurement Information Is: _X_ Currently Available ___ Available With Minor Changes	Data Elements and Sources: HPA&E tracks the data through multiple sources.

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	Accountability for Meeting Target: Mr Spruell/RADM Carrato	Tracking / Reporting Responsibility: Dr Guerin	Measure Availability: TBD Target: TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	5 of 9 Measures	6 of 9 Measures	7 of 9 Measures	8 of 9 Measures	9 of 9 Measures

C-2 Clinical Quality Metrics

Measure	Target	Notes.
Breast Cancer Screening	78.19	
Cervical Cancer Screening	77.74	
Prenatal Care in 1st Trimester	80.00	Arbitrary. New measure for HEDIS – quantile data not yet available.
Follow-up After Hospitalization for Mental Health	80.00	
Check-up after delivery	90.00	Arbitrary.
Beta Block After Heart Attack	93.33	
Eye Exam for Diabetes	54.17	
Asthma Management	65.54 for ages 5-9 62.16 for ages 10-17 67.18 for ages 18-56	Must hit all three to get credit for this measure.
Advised to Quit Smoking	90.00	Arbitrary

C-3 Measure—External Customer Perspective
19 Sep 02

Strategic Objective: Improve Customer Service Measure: Satisfaction with Health Plan Measurement Intent: Overall satisfaction with MHS	Frequency of Update: TBD Units of Measure: % satisfied

Measurement Definition/Formula: **M=N/D x 100**, where **M**=the percentage of DOD beneficiaries who responded favorably." **N**=the number of "Somewhat Satisfied," "Very Satisfied," or "Completely Satisfied" responses; and **D**= respondents.

Notes/Assumptions:	Next Steps:
Measurement Information Is: __X_ Currently Available ___ Available With Minor Changes	Data Elements and Sources: Customer Satisfaction Survey

Source For and Approach to Setting Targets:

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability: TBD Target: TBD
Mr Spruell/RADM Carrato	Mr Spruell/RADM Carrato	Dr Guerin	

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	55%	57%	60%	63%	65%

C-4 Measure—External Customer Perspective
19 Sep 02

Strategic Objective: Build Healthy Communities Measure: Population Health 2010 metrics Measurement Intent: Healthy People 2010 is the prevention agenda for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.	Frequency of Update: Quarterly Units of Measure:

Measurement Definition/Formula: See attached slide

Notes/Assumptions:	Next Steps:
Measurement Information Is: _X_ Currently Available ___ Available With Minor Changes	Data Elements and Sources: See attached slide for data elements. Source = Health Care Survey of DoD Beneficiaries, SIDR

Source For and Approach to Setting Targets:

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure
Leadership Team	Mr Spruell/RADM Carrato	Dr Guerin/LTC Schwerin	Availability: TBD Target: TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	5 of 9 Measures	6 of 9 Measures	7 of 9 Measures	8 of 9 Measures	9 of 9 Measures

C-4 Healthy People 2010 Index

Tobacco	Reduce Tobacco Use <15%; 20% for Active Duty Members
Family Planning	Reduce pregnancies aged 15-17 to < 50/1000 girls; no AD
Unintentional Injuries	Reduce unintentional injury hospitalization rate < 754/100,000
Environmental Health	Reduce asthma hospitalizations <160/100,000
Maternal and Infant Health	Increase Visit in 1st Trimester >90%
	Reduce Low Birthweight Rate < 5%; no AD
	Reduce Infant Mortality Rate < 7/1000; no AD
Heart Disease and Stroke	Increase to 75% cholesterol screening rates
Cancer	Increase mammography (<24 mos.,aged >50) rate > 60%; no AD
	Increase Pap Smear (<36 mos., aged > 18) Rate > 85%
Clinical Preventive Services	Increase population with specific source of primary care >95%

F-1 Measure—Financial Perspective
19 Sep 02

Strategic Objective: Determine and Account for Readiness Costs Measure: Cost of Readiness Measurement Intent: The excess cost to the department of operating its own health care system (direct care) over the cost of buying current care for all beneficiaries.	Frequency of Update: TBD Units of Measure: Dollars

Measurement Definition/Formula: Subtracting the purchased care value of all care produced (direct and purchased) from the total budget executed for the direct care, purchased care, and line medical assets.

Notes/Assumptions: A methodology exists for determining both readiness costs and the cost of providing healthcare for all beneficiaries	Next Steps: Await PA&E study.
Measurement Information Is: ___ Currently Available _X__ Available With Minor Changes	Data Elements and Sources: PA&E Study and internal cost calculations

Source For and Approach to Setting Targets: PA&E Study and internal cost calculations

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Dick Guerin, Ms. Rachel Foster	Target: 15 Nov 02

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**TBD**	**TBD**	**TBD**	**TBD**	**TBD**

F-2 Measure—Financial Perspective
19 Sep 02

Strategic Objective: Obtain Appropriate Resources Measure: % DHP Budget growth within accepted national healthcare inflationary index Measurement Intent: Determine if DHP budget is consistent with national health care inflationary rate	Frequency of Update: Yearly Units of Measure: Ratio

Measurement Definition/Formula: % Budget increase/ % increase Medical Consumer Price Index

Notes/Assumptions: The cost to operate the MHS is consistent with national trends in healthcare and can be monitored by the Medical Consumer Price Index	Next Steps: Identify health care resource requirements based on historic trends and industry forecasts to assist budget development.
Measurement Information Is: _x__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: MHS budget and Medical Consumer Price Index

Source For and Approach to Setting Targets: External Benchmark (Medical Consumer Price Index) and real property life-cycle maintenance and capital equipment maintenance

Target Setting Responsibility: Leadership Team	Accountability for Meeting Target: Mr Ford/Lt Gen Taylor	Tracking / Reporting Responsibility: Mr. Ed Chan	Measure Availability: Target: Growth DHP aligns with Annual Growth of MCPI

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**TBD**	**TBD**	**TBD**	**TBD**	DHP aligns with MCIP

F-2 Measure—Financial Perspective
19 Sep 02

Strategic Objective: Obtain Appropriate Resources Measure: Real property life-cycle maintenance and recapitalization Measurement Intent: Determine the life cycle recapitalization rate of medical treatment facilities	Frequency of Update: Yearly Units of Measure: Recap Rate

Measurement Definition/Formula: % of medical facilities meeting industry accepted standard property life cycles

Notes/Assumptions: Real property life-cycle maintenance and capital investments should be consistent with industry standard measures	Next Steps: Codify mechanism for collecting and reporting data. Develop methodology and provide report of MHS facilities replacement timelines consistent with health care industry benchmarks
Measurement Information Is: ___ Currently Available _X__ Available With Minor Changes	Data Elements and Sources: Facility Recap Rate based on the MHS version of the USD(AT&L) facilities resoration and Modernization metric of 30 Years

Source For and Approach to Setting Targets: External Benchmarks

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Col Thom Kurmel/TMA/RM/FLCM	Target: 30 years

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**Develop metric**	**Implement Program Changes and begin planning**	**TBD**	**TBD**	**Bldgs 30 Years**

F-3 Measure—Financial Perspective
19 Sep 02

Strategic Objective: Optimize Stewardship of Resources Measure: Healthcare Efficiency of the MHS ($ output/ $ input) Measurement Intent: Provide visibility and accountability of MHS resources.	Frequency of Update: Yearly Units of Measure: Ratio

Measurement Definition/Formula: This metric divides the purchased care dollar value for all care purchased or made by the budget executed for health care and line medical assets in the Department of Defense

Notes/Assumptions: The efficiency of the MHS may be calculated by dividing the output of services by the financial input (budget)	Next Steps: Define parameters and develop targets
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements and Sources: All Region Server (SIDR,HCSR,DEERS)

Source For and Approach to Setting Targets:

Target Setting Responsibility: Leadership Team	Accountability for Meeting Target: Mr Ford/Lt Gen Taylor	Tracking / Reporting Responsibility: Dr. Dick Guerin	Measure Availability: Target: TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**TBD**	**TBD**	**TBD**	**TBD**	TBD

F-3 Measure—Financial Perspective
19 Sep 02

Strategic Objective: Optimize Stewardship of Resources Measure: Healthcare Efficiency of the Direct Care System ($ direct care output/ $ direct care input) Measurement Intent: Provide visibility and accountability of MHS resources.	Frequency of Update: Yearly Units of Measure: Ratio

Measurement Definition/Formula: This metric divides the purchased care value of care produced by the direct care system by the amount budget executed for the direct care system and line medical assets

Notes/Assumptions: The efficiency of the Direct Care System may be calculated by dividing the output of services by the financial input (budget)	Next Steps: Define parameters and develop targets
Measurement Information Is: _X__ Currently Available ___ Available With Minor Changes	Data Elements: All Region Server (SIDR,HCSR,DEERS)

Source For and Approach to Setting Targets:

Target Setting Responsibility:	Accountability for Meeting Target:	Tracking / Reporting Responsibility:	Measure Availability:
Leadership Team	Mr Ford/Lt Gen Taylor	Dr. Dick Guerin	Target: TBD

Target	2003	2004.	2005	2006	2007
Lists numerical targets by year for the various component of the formula where relevant. For 2000 list targets by quarter and year.	**TBD**	**TBD**	**TBD**	**TBD**	TBD

Appendix D

L&G1 Initiative—Learning & Growth Perspective

Initiative Name: Develop MHS Science & Technology Program
Objective Name: Leverage Science and Technology
Leadership Team Sponsors: LTG Peake/Mr. Reardon
Core Team Sponsors: Brig Gen Kelley/CAPT Smith
Initiative POC: Dr. Sal Cirone

Start Date: Oct 02
End Date: 1 Oct 03

Intent: Define what we are trying to accomplish, develop a baseline and develop a communication strategy to educate TARA chairs on MHS objectives

Specific steps with milestones (dates):

1.	Establish MHS Science and Technology definition, goal and objectives and vision	Feb 03
2.	Develop a S&T agenda	Feb 03
3.	Inventory current initiatives and establish a baseline	June 03
4.	Prioritize S&T goals	June 03
5.	Link to TARA and educate Chairs on MHS strategic objectives	July 03

Budget/Resources:

L&G2 Initiative—Learning & Growth Perspective

Initiative Name: Develop MHS Program for recruitment and retention
Objective Name: Recruit, retain and develop personnel
Leadership Team Sponsors: LTG Peake/Mr. Reardon
Core Team Sponsors: Brig Gen Kelley/CAPT Smith
Initiative POC: CAPT Smith

Start Date: Oct 02
End Date: 1 Oct 03

Intent: Develop a process linking data about our critical medical personnel shortfalls with the process for defining attraction and retention incentive bonuses for medical professionals.

Specific steps with milestones (dates):

1.	Realign medical bonus work group and accessions/retention executive group into a single IPT	Nov 02
2.	Recharter FORB	Nov 02
3.	Accessions/Retention IPT monitors fill rates and reports to FORB	May 03
4.	Proposed incentives package for FY 04 presented to FORB	July 03

Budget/Resources:

L&G-2 Initiatives—Learning and Growth

Initiative Name: Employee Satisfaction Survey (unified survey)
Objective Name: Recruit, retain and develop personnel
Leadership Team Sponsors: Mr. Reardon, LTG Peake
Core Team Sponsors: Brig Gen Kelley, CAPT Smith
Initiative POC: Dr. Guerin

Start Date:
End Date:

Intent: Develop and field the survey, analyze, interpret, and report results.

Specific steps with milestones (dates):	Milestone Date
Field the Employee Satisfaction Survey	31 March 2003
Receive Data From Employee Satisfaction Survey	30 June 2003
Analyze, Interpret, and Brief Results	scheduled during Q4, FY 03

Budget/Resources:

L&G Initiatives—Learning and Growth Perspective

Initiative Name: Limited Deployment of CHCS II
Objective Name: Patient/provider focused information systems which enhance capability
Leadership Team Sponsors: LTG Peake / Mr. Reardon
Core Team Sponsors: Brig Gen Kelly / CAPT Smith
Initiative POC: Mr. Pace
Service POCs: COL Chiang, USA/ CDR Sowell, USN / Col Lee, USAF

Start Date: 1 Oct 2002

End Date: 30 Sept 2003

Intent: Limited initial deployment of CHCS II Block 1, in order to evaluate and refine training and implementation approach, to resolve current issues, and to develop effective strategies for business process reengineering. Based on the results of limited deployment, obtain MDA and SMMAC decision to proceed with full scale deployment.

Specific Steps:	**Milestone Date:**
Obtain MDA and SMMAC decision for Block 1 to enter limited deployment	Nov 2002
Complete analysis of training strategy and study of industry best practices related to the introduction of CHCS II into organizations	Jan 2003
Fully deploy at Ft. Eustis and gather lessons learned	Mar 2003
Deploy at up to 6 additional new sites applying lessons learned at Ft. Eustis and results of training analysis	June 2003
Apply further lessons learned and results of training analysis in order to update deployment and training plan	Aug 2003
Obtain MDA and SMMAC decision to proceed with worldwide deployment	Sept 2003

Budget/Resources:

L&G-3 Initiatives—Learning and Growth Perspective

Initiative Name: TRICARE Online (TOL)
Objective Name: Patient/Provider-Focused Information System Which Enhances Capability
Leadership Team Sponsors: Mr. James Reardon
Core Team Sponsors: Mr. James Reardon
Initiative POC: CAPT Brian Kelly
Service POCS: MAJ Bonita Wilson, USA; CAPT Kevin Helmrick, USAF; CAPT Christine Bruzek-Kohler, USN

Start Date: 2003
End Date: 2007

Intent:
Improve Patient Access and Population Health Thru the Strategic Use of the Internet

Specific steps:		**Milestone Date:**
1.	Acquisition Milestone C (Worldwide Deployment Decision)	Jan 2003
2.	Self-Referral Appointment Capability Online	Jan 2003
3.	Pharmacy Refill Capability	July 2003
4.	Complete Worldwide Deployment of TOL Block 1	April 2003
5.	Complete Worldwide Deployment of TOL Blocks 1 & 2	Sept 2003
6.	Gradual Increase in Number of Appointments Made Over the Internet by 2007 thru Marketing and Expansion of Appointments Available	2007

Budget/Resources:

L&G4 Initiative—Learning & Growth Perspective

Initiative Name: Develop Tri-Service process for inter-Service resource sharing
Objective Name: Enhance Jointness
Leadership Team Sponsors: LTG Peake/Mr. Reardon
Core Team Sponsors: Brig Gen Kelley/CAPT Smith
Initiative POC: CAPT Smith

Start Date: Oct 02
End Date: 1 Oct 03

Intent: Develop a process to evaluate location of critical medical personnel shortfalls by Service and to share resources across Service lines, where possible and appropriate

Specific steps with milestones (dates):

1.	Recharter FORB	Nov 02
2.	Services report projected critical vacancies for Summer 03 to FORB	Jan 03
3.	FORB presents recommendations for resource sharing to SMMAC	Mar 03

Budget/Resources:

L&G4 Initiative—Learning & Growth Perspective

Initiative Name: Create Task Force to make recommendations on MHS Executive Development and utilization
Objective Name: Enhance Jointness
Leadership Team Sponsors: LTG Peake/Mr. Reardon
Core Team Sponsors: Brig Gen Kelley/CAPT Smith
Initiative POC: CAPT Smith

Start Date: Jan 03
End Date: 1 Oct 03

Intent: Establish a Task Force to 1) review current status of Executive Skills Development programs across MHS, make recommendations for changes/improvements in programs, and 2) review current status of assignment and utilization of Medical Department Flags and make recommendations for improvement of system

Specific steps with milestones (dates):

1.	Establish Task Force	Jan 03
2.	Evaluate Executive Skills Development Programs and report findings/recommendations	
3.	to SMMAC	Jun 03
4.	Evaluate Flag Officer assignments and report findings/recommendations to SMMAC	Oct 03

Budget/Resources:

R-1 Initiatives—Readiness Theme

Initiative Name: Individual medical readiness
Objective Name: Provide a medically ready total force
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs: Army: Navy: AF:Col VanHook

Start Date: Sept 02
End Date:

Intent: Develop, implement, and monitor individual medical readiness to deploy indicators. Provide commanders and medical personnel with real time status of individual medical readiness (IMR) requirements for members. Monitor Individual Medical Readiness criteria as part of the overall effort to proactively monitor the deployability of the active-duty base force.

Specific steps:	Milestone Date
1. Individual medical readiness to deploy indicators	1. 31 Oct 02
2. Establish Joint Military Vaccination Program Office, support National Long-Range Vaccine Council (Policy 31 Oct 02, Operations 31 May 03)	2. 31 Oct 02, 31 May 03
3. Establish and prioritize medical CBRNE threats and associated countermeasures; develop "scorecard" to assess ongoing progress in development of each countermeasure	3. 1 Nov 02
4. Issue DoD Directive: Force Health Protection	4. 31 May 03
5. Improve pre-/post deployment health assessment tools	5. 30 Sep 03
6. Adjust policies and programs designed to improve operational forces' health and fitness to deploy	6. 31 Oct 02
7. Effective implementation of DoD's anthrax vaccination policies and program	7. 31 Dec 02
8. Implement smallpox response plan; develop and implement smallpox vaccination policy approved by DoD leadership	8. 31 Dec 02

Budget/Resources:

R-1 Initiatives—Readiness Theme

Initiative Name: Individual medical readiness RC
Objective Name: Provide a medically ready total force
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs:

Start Date: Oct 02
End Date:

Intent: Develop, implement, and monitor individual medical readiness to deploy indicators for Guard and Reserve. Provide commanders and medical personnel with real time status of individual medical readiness (IMR) requirements for members. Monitor Individual Medical Readiness criteria as part of the overall effort to proactively monitor the deployability of RC.

Specific steps with milestones (dates):	Milestone Date
1. Evaluate and propose options for capturing fitness and health data on Guard and Reserve forces	1. 30 Nov 02
2. Determine sources of Guard/Reserve funding for medical readiness and make recommendation to Leadership Team for policy and/or procedure changes	2. 31 Dec 02
3. Guard and Reserve Deployment Indicators	3. 31 Jan 03

Budget/Resources:

R-1 Initiatives—Readiness Theme

Initiative Name: DoD medical surveillance system
Objective Name: Provide a medically ready total force
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs:

Start Date: Oct 02
End Date:

Intent: Implement an integrated, comprehensive DoD medical surveillance system

Specific steps with milestones (dates):

	Milestone Date
1. Enhance medical health surveillance tool set for theaters of operation by developing an Operational Combatant Commanders' SIPRNET web site permitting centralized data management of environmental risk assessment and personnel location information	1. 31 Dec 02
2. Establish common architecture for capturing force medical surveillance data throughout the MHS using common metrics and data standards. Policy memo establishing common metrics and data standards for force-wide medical surveillance.	2. 31 Jan 03
3. Improve deployment occupational and environmental health surveillance (OEHS).	3. 30 Sep 03
4. Establish a single DoD medical surveillance system.	4. 30 Sep 03
5. Improve processes used to incorporate individual service-member medical records from deployments into their permanent health records in CONUS	5. 31 Jan 03
6. Provide advanced diagnostic, surveillance, prevention, and treatment capabilities through focused/prioritized Medical RDT&E that fill critical gaps in force health protection	6. 30 Nov 02
7. Establish metrics for assessing the effectiveness of the Post Deployment Health Clinical Practice Guidelines and the Deployment Health Centers' activities	7. 30 Apr 03

Budget/Resources:

R-2 Initiatives—Readiness Theme

Initiative Name: Ensure policy development and financial influence support OPLAN taskings
Objective Name: Provide a ready medical capability
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs:

Start Date:
End Date:

Intent: Support Tri-Service, OPLAN tasked medical units reporting C1 or C2 in the Status of Resources and Training System (SORTS).

Specific steps with milestones (dates):	**Milestone Date**
Develop a reporting mechanism to provide SORTS data to leadership team.	**31 Jan 03**

Budget/Resources:

R-2 Initiatives—Readiness Theme

Initiative Name: Define common core medical requirements for joint medical response operations
Objective Name: Provide a ready medical capability
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs:

Start Date: Oct 02
End Date:

Intent: Define common core medical requirements for joint medical response operations, including related training, equipment and exercise standards

Specific steps with milestones (dates):	**Milestone Date**
1. Define core medical requirements for joint medical response operations, including related training, equipment and exercise standards	1. 31 Mar 03
2. Determine medical requirements in light of "de facto doctrine" (as defined by actual theater medical services delivered in theaters of operation since 1993)	2. 31 Mar 03
3. Assess programs and policy of health threat/countermeasure training and education for deploying military forces	3. 31 Mar 03

Budget/Resources:

Q-1 Initiatives—Improve Patient Safety

Initiative Name: Share aggregate data results, deploy Taproot, link MedMaRx across MHS
Objective Name: Improve patient safety:
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: CAPT Stewart

Start Date:Oct 02
End Date:

Intent: Quantify near misses across the system and incentivize reporting of less serious events with potential to improve safety of system

Specific steps with milestones (dates):

1. **Train staff at all Medical Treatment Facilities on patient safety concepts, reporting requirements and analysis techniques – initial training completed in August 2002, training of new staff members is ongoing**
2. **Services hire Patient Safety Managers for selected facilities – January 2003**
3. **All MTFs submit monthly reports to AFIP – November 2002**
3. **Feedback from AFIP to MTFs and Services at least quarterly – January 2003**
4. **Incorporate lessons learned from close calls in Patient Safety website and newsletter – January 2003**
5. **Pilot new aggregate review process - March 2003**
6. **Implementation of TapRoot in MTFs that are not current TapRoot users - June 2003**
7. **Implementation of MedMARx in MTFs that are not current MedMARx users – May 2003**
8. **Implementation of MedMARx Multi-facility Module - February 2003**

Budget/Resources:

Q-2 Initiatives—Quality Theme

Initiative Name: Establish process to examine benchmark organizations to share successful ideas.
Objective Name: Increase patient-centered focus
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: Dr. Guerin

Start Date:
End Date:

Intent: Identify and adopt successful patient-centered practices throughout the MHS.

Specific steps with milestones (dates):	**Milestone Date**
Identify MHS Benchmark organizations and their areas of success.	6 December 2002
For each Benchmark organization, identify the lessons that can be adopted or exported	31 March 2003
Present lessons to leadership	Scheduled after 31 March.

Budget/Resources:

Q-2 Initiatives—Quality Theme

Initiative Name: Monitor level of success of Tri-Service OB product line..
Objective Name: Increase patient-centered focus
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: Dr. Guerin

Start Date:
End Date:

Intent: Establish a uniform maternal-infant product line and adopt successful patient-centered practices throughout the MHS.

Specific steps with milestones (dates):	**Milestone Date**
Have the OB product line workgroup recommend measures to retain OB patients.	30 Oct 02
Request legislative relief for loss of NAS authority and bundled pricing	Next legislative cycle
Track numbers of deliveries in direct care system and customer satisfaction	Ongoing

Budget/Resources:

Q-2 Initiatives—Quality Theme

Initiative Name: Implement Access to Care OIPT recommendations
Objective Name: Increase patient-centered focus
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: Capt Brian Kelly

Start Date:
End Date:

Intent: Adopt successful patient-centered practices throughout the MHS.

Specific steps with milestones (dates):	**Milestone Date**
Task the Access to Care OIPT to brief the Leadership Group for specific initiatives to improve access to care.	31 March 2003

Budget/Resources:

Q-2 Initiatives—Quality Theme

Initiative Name: Link Beneficiary Satisfaction to Employee Satisfaction
Objective Name: Increase patient-centered focus
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: Dr. Guerin

Start Date:
End Date:

Intent: Adopt successful patient-centered practices throughout the MHS.

Specific steps with milestones (dates):	**Milestone Date**
Field the Employee Satisfaction Survey	n..l.t. 31 March 2003
Receive Data from the Employee Satisfaction Survey	n.l.t. 30 June 2003
Link the Beneficiary Satisfaction Survey with the Employee Satisfaction Survey	n.l.t. 30 September 2003

Budget/Resources:

Q-2 Initiatives—Quality Theme

Initiative Name: Develop a Survey Plan for POS surveys
Objective Name: Increase patient-centered focus
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: Dr. Guerin

Start Date:
End Date:

Intent: Adopt successful patient-centered practices throughout the MHS.

Specific steps with milestones (dates):	**Milestone Date**
Brief SMMAC on Current Survey Program and Considerations for POS Surveys	scheduled during Q1, FY 2002
Develop Tri-Service Demonstration	schedule launch during Q3, FY 2003
Initial Results of Demonstration of MTF POS Survey	30 June 2003

Budget/Resources: Already Funded

Q-3 Initiatives—Quality Theme

Initiative Name: Establish a process to evaluate data and determine causes of significant differences between MHS & civ. rates.
Objective Name: Improve Health Outcomes
Leadership Team Sponsors: VADM Cowan, Dr. Tornberg
Core Team Sponsors: MGEN Adams, CAPT Smith
Initiative POC: Col Daniel Cohen

Start Date:
End Date:

Intent: Improve Health Outcomes

Specific steps with milestones (dates):

	Milestone Date
Analysis of levels and trends by HPA&E in support of the Clinical Quality Forum	31 December 2002
Analysis of reasons for differences in preventable admission levels by Clinical Quality Forum (with analytic support from HPA&E)	31 March 2003

Budget/Resources: Already Funded

E-1 Initiatives—Efficiency Theme

Initiative Name: Increase VA-DoD sharing agreements
Objective Name: Improve interoperability with partners
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: Dr. Guerin, Col Cunningham
Initiative POC: CDR McDonald
Service POCs:

Start Date: Oct 02
End Date:

Intent: Quantify and increase the value of DoD/VA Sharing

Specific steps with milestones (dates):

1. -Quantify and qualify where sharing agreements exist (to include formal and informal arrangements)
2. -Identify best practices in DoD/VA resource sharing
3. - Establish criteria for administration and management of the Joint Incentive Fund

Milestones date

Current working DoD/VA Strategic Planning. Milestone dates will be matched

Budget/Resources:

E-2 Initiatives—Efficiency Theme

Initiative Name: Provider availability and support staff/facility support standards
Objective Name: Enhance system productivity
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: Dr. Guerin, Col Cunningham
Initiative POC: Dr Opsut
Service POCs:

Start Date: Oct 02
End Date:

Intent: Develop, implement, and monitor provider availability, RVU/FTE, RWP/FTE and support staff/facility support standards

Specific steps:	**Milestones date**
Standardize definition of provider availability, RVU/FTE, RWP/FTE	Nov 15 02
Compute current values of provider availability, RVU/FTE, RWP/FTE by MTF, Service	Nov 30 02
Develop targets for provider availability, RVU/FTE, RWP/FTE	Dec 15 02
Incorporate provider availability, RVU/FTE, RWP/FTE into quarterly MHSER	Feb 15 03
Develop subgoals for RVU/FTE by specialty	Mar 15 03
Conduct/contract study of support staff/facility staff standards	Sep 15 03

Budget/Resources:

E-2 Initiatives—Efficiency Theme

Initiative Name: Hospital occupancy and inpatient admission rates
Objective Name: Enhance system productivity
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: Dr. Guerin, Col Cunningham
Initiative POC: Dr Opsut
Service POCs:

Start Date: Oct 02
End Date:

Intent: Develop defined methodology and thresholds and monitor hospital occupancy and inpatient admission rates of MHS

Specific steps:	**Milestones Dates**
Calculate inpatient admission rates for MTF Prime enrollees (data already available)	Dec 15 02
Adopt a standard methodology for calculating beds (e.g., adopt CMS standard)	Nov 15 02
Collect from the services the number of beds by MTF using a standard definition	Dec 15 02
Calculate current occupancy rates by MTF and Service	Jan 15 03
Develop targets for occupancy rate	Jan 31 03
Incorporate hospital occupancy and admission rates into quarterly MHSER	Feb 15 03

Budget/Resources:

E-2 Initiatives—Efficiency Theme

Initiative Name: Prime leakage
Objective Name: Enhance system productivity
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: Dr. Guerin, Col Cunningham
Initiative POC: Dr Opsut
Service POCs:

Start Date: Oct 02
End Date:

Intent: Develop defined methodology and thresholds for prime leakage

Specific steps:	**Milestones Dates**
Adopt a standard methodology for MTF capability (e.g. CPT, DRG codes)	Dec 15 02
Calculate current occupancy rates by MTF, Service	Jan 15 03
Develop targets for Prime Leakage (Inpatient and Outpatient)	Feb 15 03
Incorporate Prime Leakage into quarterly MHSER	Mar 15 03

Budget/Resources:

E-2 Initiatives—Efficiency Theme

Initiative Name: Cost/RVU
Objective Name: Enhance system productivity
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: Dr. Guerin, Col Cunningham
Initiative POC: Dr Opsut
Service POCs:

Start Date: Oct 02
End Date:

Intent: Develop methodology and monitor cost/APG of both direct and private sector care for MTF enrollees

Specific steps:	**Milestones Dates**
Adopt a standard methodology for calculating cost/APG	Nov 15 02
Calculate current cost/APG by MTF and Service	Dec 15 02
Develop targets for cost/APG	Jan 15 03
Incorporate cost/APG into quarterly MHSER	Mar 15 03
Determine appropriate inflation adjustments for future year targets	Oct 15 03

Budget/Resources:

E-3 Initiatives—Efficiency Theme

Initiative Name: Staff and Fund requirements
Objective Name: Identify & prioritize requirements
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: Dr. Guerin, Col Cunningham
Initiative POC: Ms Jean Storck
Service POCs:

Start Date: Nov 02
End Date:

Intent: Respond to PA&E Study by developing a methodology to staff and fund all justified readiness requirements

Specific steps with milestones (dates):

	Milestone Dates
1. Work with PA&E to identify medical readiness staffing requirements for DHP	1. Feb 03
2. Incorporate study results in POM and BES requirements for funding at 100%	2. Mar 03
3. Determine additional non-readiness requirements to support benefit mission	3. Mar 03

Budget/Resources:

C-1 Initiatives—External Customer Perspective

Initiative Name: Individual medical readiness
Objective Name: Provide a medically ready total force
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs: Army: Navy: AF:Col VanHook

Start Date: Sept 02
End Date:

Intent: Develop, implement, and monitor individual medical readiness to deploy indicators. Provide commanders and medical personnel with real time status of individual medical readiness (IMR) requirements for members. Monitor Individual Medical Readiness criteria as part of the overall effort to proactively monitor the deployability of the active-duty base force.

Specific steps:	Milestone Date
1. Individual medical readiness to deploy indicators	1. 31 Oct 02
2. Establish Joint Military Vaccination Program Office, support National Long-Range Vaccine Council (Policy 31 Oct 02, Operations 31 May 03)	2. 31 Oct 02, 31 May 03
3. Establish and prioritize medical CBRNE threats and associated countermeasures; develop "scorecard" to assess ongoing progress in development of each countermeasure	3. 1 Nov 02
4. Issue DoD Directive: Force Health Protection	4. 31 May 03
5. Improve pre-/post deployment health assessment tools	5. 30 Sep 03
6. Adjust policies and programs designed to improve operational forces' health and fitness to deploy	6. 31 Oct 02
7. Effective implementation of DoD's anthrax vaccination policies and program	7. 31 Dec 02
8. Implement smallpox response plan; develop and implement smallpox vaccination policy approved by DoD leadership	8. 31 Dec 02

Budget/Resources:

C-1 Initiatives—External Customer Perspective

Initiative Name: Individual medical readiness RC
Objective Name: Provide a medically ready total force
Leadership Team Sponsors: Ms. Embrey, LTG Peake
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Col Cunningham
Service POCs:

Start Date: Oct 02
End Date:

Intent: Develop, implement, and monitor individual medical readiness to deploy indicators for Guard and Reserve. Provide commanders and medical personnel with real time status of individual medical readiness (IMR) requirements for members. Monitor Individual Medical Readiness criteria as part of the overall effort to proactively monitor the deployability of RC.

Specific steps with milestones (dates):	Milestone Date
1. Evaluate and propose options for capturing fitness and health data on Guard and Reserve forces	1. 30 Nov 02
2. Determine sources of Guard/Reserve funding for medical readiness and make recommendation to Leadership Team for policy and/or procedure changes	2. 31 Dec 02
3. Guard and Reserve Deployment Indicators	3. 31 Jan 03

Budget/Resources:

C-2 Initiatives—External Customer Perspective

Initiative Name: Implement TRICARE Global Remover Overseas Healthcare Contract
Objective Name: Deliver high quality care anywhere
Leadership Team Sponsors: Mr. Spruell/RADM Carrato
Core Team Sponsors: Dr. Guerin
Initiative POC: CAPT Valentin
Service POCS:

Start Date: Oct 02
End Date: Sep 03

Intent: Ensure there is a consistent healthcare benefit for Active Duty and Active Duty Family Members in remote overseas locations

Specific steps:	**Milestone Date:**
Complete and distribute the Request for Proposal for the contract	Oct 02
Award the contract	Mar 03
Complete the transition process and begin implementation of the new contract	Sep 03

Budget/Resources:

C-2 Initiatives—External Customer Perspective

Initiative Name: Integrate Clinical Quality Forum recommendations into the TRICARE program **Objective Name:** Deliver high quality care anywhere **Leadership Team Sponsors:** Mr. Spruell/RADM Carrato **Core Team Sponsors:** Dr. Guerin **Initiative POC:** COL Cohen **Service POCS:**	**Start Date:** **End Date:**

Intent: Integrate the recommendations of the Clinical Quality Forum into executable projects in the TRICARE program with particular emphasis on requirements derived from the National Defense Authorization Act

Specific steps:	**Milestone Date:**
Adopt Medicare's health Professional Shortage Areas (HPSA) reimbursement system	Mar 03
Implement the Prospective Payment System for skilled nursing facilities and home Health agencies	Sep 03

Budget/Resources:

C-3 Initiatives—External Customer Perspective

Initiative Name: Increase electronic submission of claims **Objective Name:** Satisfaction with Health Plan **Leadership Team Sponsors:** Mr. Spruell/RADM Carrato **Core Team Sponsors:** Dr. Guerin, RADM Arthur **Initiative POC:** **Service POCS:**	**Start Date:** **End Date:**

Intent: Decrease the level of dissatisfaction with the health plan by increasing the number of electronic claims allowing for improved turn-around for physician payment. The assumption is that faster, more accurate payment will decrease the hassle factor for patients

Specific steps:	**Milestone Date:**
Develop plan to ensure full compliance with electronic claims submission rates specified in the T-Nex Managed Care Support Contracts	Mar 03
Achieve a 5% increase in non-pharmacy, non-TFL electronic claims submission within the current MCS contracts (increase from 23% to 28% ECS)	Sep 03
Implement plan to have 100% of claims from Network providers (with exceptions as permitted in the RFP)	Per T-Nex implementation

Budget/Resources:

C-3 Initiatives—External Customer Perspective

Initiative Name: Improve TRICARE Information Center (communication of plan)
Objective Name: Satisfaction with Health Plan
Leadership Team Sponsors: Mr. Spruell/RADM Carrato
Core Team Sponsors: Dr. Guerin, RADM Arthur
Initiative POC:
Service POCS:

Start Date: 1Oct02
End Date: 30Jun02

Intent: Improve customer/beneficiary access to information through the TRICARE Information Center (TIC)

Specific steps:	**Milestone Date:**
Award the TIC Contract	Mar03
Begin implementation of new contract	Jun03

Budget/Resources:

C-4 External Customer Perspective

Initiative Name: MHS Optimization and Population Health Support Center
Objective Name: Build Health Communities
Leadership Team Sponsors: Mr. Spruell, RADM Carrato
Core Team Sponsors: Dr Guerin
Initiative POC: CDR Peggy Williams
Service POCS:

Start Date: 1Oct02
End Date: 30Sep03

Intent: Provide an online "family of services" in an educational format for staff members of MHS --Resource Center, the Learning Center, and the Virtual Optimized Clinic. Each forum supports change by translating the MHS strategies for optimization and population health improvement into terms which are understandable, relevant, and actionable. The services answer the questions related to "how", "why", and "what".

Specific steps: Over a two year process, TMA worked to develop a learning architecture to support the field and foster the reengineering efforts. This web based support center is designed to be a one-stop shopping experience for the clinic end-users. A first learning module was alpha tested at Pensacola NH in July 2001 and was well received. Three other service specific site visits were planned, during which we assessed the facilities needs for assistance with optimization and population health improvement activities, we targeted the development of new resources, and facility staff engaged in discussion forums and provided feedback to upgrade the content of learning modules. The modules have been constructed in educational format to support MHS processes based on the Klinger-Cohen business rules. After build out of information at the three sites, the website will "go live". Population of future modules will continue with part 2 of the contract and will consist of either creation of a new module or construction of a bridging module to already existing educational information which exists within TMA as part of another work group's product. Some of the proposed bridging modules will connect to Patient Safety, Coding, and HIPAA information. Milestone Date: Completion is projected by Jun 2003

Budget/Resources: For sustainment capability, there is need for contract administrative management at $5,000/year, program management in the form of a center director, two individuals to conduct help desk function, a center librarian to update, maintain, and archive reference materials.

F-1 Initiatives—Financial Perspective

Initiative Name: Identify specific readiness related costs and resolve any disconnects between the top down and bottom up review of financial data.

Start Date:
End Date:

Objective Name: Determine the Cost of Readiness
Leadership Team Sponsors: Mr. Ford, LTG Taylor
Core Team Sponsors: RADM Mateczun, Brig Gen Kelley, Col Cunningham
Initiative POC: Dr. Guerin, Ms. Foster

Intent: To quantify the costs of readiness.

Specific steps with milestones (dates):	**Milestone Date**
Definitive Costing of the Top Down calculation.	31 March 2003
Model the bottom's up approach to the cost of readiness	30 June 2003
Compare and Contrast to the Leadership Group	Schedule During 4th Quarter.

Budget/Resources:

F-2 Initiatives—Financial Perspective

Initiative Name: DHP annual growth rate
Objective Name: Obtain appropriate resources
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: MG Farmer, Col Cunningham
Initiative POC: Mr Chan
Service POCs:

Start Date: Nov 2002
End Date: Aug 2003

Intent: Identify health care resource requirements based on historic trends and industry forecasts to assist budget development. Align % DHP Annual Growth % Annual Growth of Medical consumer Price Index (MCPI)

Specific steps with milestones (dates):

Research and establish benchmark health care industry forecasts for inflation and cost growth	Dec 02
Adjust benchmark projections to reflect military health care benefit structure (study)	Jan 03
Apply adjusted benchmark forecasts to the appropriate health care product lines in budget and POM development	Apr 03
Defend budget and POM growth rates to DoD and OMB	Summer 03

Budget/Resources:

F-2 Initiatives—Financial Perspective

Initiative Name: Real property and capital equipment life cycle
Objective Name: Obtain appropriate resources
Leadership Team Sponsors: Mr. Ford, Lt Gen Taylor
Core Team Sponsors: MG Farmer, Col Cunningham
Initiative POC: Col Tom Kurmel TMA/RM
Service POCs: COL Pete Peterson (AF), COL John Becker (Army), CAPT Jim Dell (BUMED)

Start Date: OCT 02
End Date: OCT 03

Intent: Develop methodology and provide report of MHS facilities replacement timelines consistent with health care industry benchmarks

Specific steps with milestones (dates):

Step 1: Use existing TMA contract support to assist HFSC and TMA in development of the industry standard benchmark based on a foundation of work already performed by USD(AT&L) and Health Affairs.

Step 2: Reconcile the Services' inventories with their Service line property record holders

Step 3: Develop a TMA Corporate inventory database that rolls up all Service inventories

Step 4: Develop a "Q" or Quality rating for all facilities (Scale Q1-Q4)

Step 5. Build POM for Sustainment-Restoration and Modernization based on the new financial model.

Budget/Resources: Services inventory managers will require support. Services Quality assessors will require support. TMA has budgeted and obtained for contract support to assist in corporate reconciliation, contract let at year end FY 02 to be able to assist TMA and Services in this effort.

F-3 Initiatives—Financial Perspective

Initiative Name: Increase the care/cost ratio of MHS and DCS.

Start Date: Oct 02
End Date:

Objective Name: Optimize stewardship of resources.
Leadership Team Sponsors: Mr. Ford, LTG Taylor
Core Team Sponsors: MG Farmer, Col Cunningham
Initiative POC: Dr. Guerin, Ms. Foster

Intent: Increase the amount of care produced by the Direct Care system for the dollars invested in the Direct Care System.

Specific steps with milestones (dates):	**Milestone Date**
Determine the value of the care produced and the costs of the Direct Care System	30 June 2003
Brief the Leadership Group	Schedule during Q4, FY 2003

Budget/Resources:

Appendix E

Military Health System Strategic Plan

Mission

To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care

Vision

A world-class health system that supports the military mission by fostering, protecting, sustaining and restoring health

September 2002

Goals

Improve service to external customers: Our customers are the Armed Forces and all those entrusted to our care.

Enhance financial stewardship: Accomplish our mission in a cost effective manner that is visible and fully accountable.

Improve Readiness: Focus on activities to enhance readiness of military forces and the medical assets that support them.

Improve Quality: Ensure benchmark standards for health and health care are met.

Improve Efficiency: Obtain maximum effectiveness from the resources we are given.

Value our internal customers and leverage technology: Our people and our support systems are critical to giving us the capabilities to execute on all we set out to achieve.

Methodology

The Military Health System (MHS) strategic plan was developed using the Balanced Scorecard (BSC) approach. The BSC was developed in the 1990's by Drs. Robert Kaplan (Harvard Business School) and David Norton (Renaissance Solutions, Inc.). The BSC is an organizational framework and tool for describing, implementing, and managing strategy at all levels of an organization. Simply stated, the BSC is a technique to translate an organization's strategy into terms that can be easily understood, communicated, and acted upon. The BSC suggests we view the organization from a series of perspectives (Customer, Internal Business Process, Learning & Growth, External Customer and Financial), and to develop metrics, collect data and analyze it relative to each of these perspectives. The BSC describes the vision of the future for the entire organization.

A copy of the MHS Strategy Map and MHS strategy architecture can be found at appendix 1 and 2 respectively. The MHS strategy map displays those objectives the Leadership Team (described below) feels are critical to accomplishing the MHS mission. The MHS strategy architecture provides further definition to each perspective.

The leadership team included the ASD(HA), PASD(HA), DASDs(HA), three Service Surgeons General, J-4 Medical Representative, Reserve Affairs Medical Representative, and the MHS Chief Information Officer. The leadership team was responsible for reviewing and approving each part of the strategic plan development. A core team comprised of the Deputy Surgeons General and other key staff invested significant time in developing the goals and objectives contained within this plan. It represents a collaborative effort to move the Military Health System (MHS) in a new direction by creating a culture of transformation.

To support the integration and alignment of the MHS Strategic Plan within the MHS, a strategic planning "Eagles Group" has been created to work issues related to the items listed below. Membership includes a representative from each Service, HA/TMA.

- Ongoing strategic/business plan
- Mapping current working groups to strategy
- Metric consolidation
- Education and communication
- Alignment

- Possible impediments
- Enablers

Goals, objectives, measurements, and targets are contained within this document. A few of the targets are being refined by the process owners and will be presented to the Leadership Team for approval.

Assumptions

This plan represents a time span of six years (current + five). Within the objectives are focused measurements that are intended to drive a change in MHS performance and where applicable, measurements from the performance contract (compliance measures) are included. More detailed information on the performance contract measurements can be found at appendix 3. The development process assumed the MHS would have an executable budget for the time span covered under this document. A non-executable budget or a large scale sustained deployment of medical assets would significantly impact our ability to execute this plan.

Communication/Education

Health Affairs has established a strategic planning website, containing our balanced scorecard, architecture, and a briefing of MHS strategic planning. The briefing will describe the balance scorecard approach as well as describe the MHS scorecard.

Since each Service approaches strategic planning differently, they will internally communicate the MHS BSC to the degree they feel is necessary to support MHS strategic planning. This is necessary since the Services must also incorporate Service specific strategic planning requirements. Health Affairs will be responsible for communication of the MHS BSC to HA/TMA personnel and other DoD or federal agencies who may be interested.

Communication to HA/TMA personnel will be accomplished at forums like the "all hand" meeting, directors, meeting, and upon request. Communication to outside agencies will be accomplished through the Health Affairs website, tri-folds and any other avenue deemed appropriate by the ASD(HA).

Evaluation Process

- Meetings. As previously stated, this planning process involved a significant investment of time on the part of both the leadership and core teams. In order not to lose the momentum created over the development process, quarterly leadership team meetings will be held to evaluate the progress made towards established targets.

- Measures Reporting. Leadership Team members will be provided a quarterly report providing progress made towards established goals and initiatives. An example of the reporting format can be found at appendix 4. An annual report will detail the progress made towards objectives.

Strategic Plan Format

There are five perspectives within this plan. Contained within these perspectives are the objectives that were approved by the MHS Leadership Team.

- Learning and Growth Perspective – the leadership team felt it was important to retain and develop our people and to provide them the technology and systems they need to accomplish their jobs. This can best be done by leveraging the benefits we achieve by working jointly.
- Internal Perspective
    - Readiness Theme – we must have a medical ready total force and a ready medical force.
    - Quality Theme – we must improve the health outcomes (both restorative and preventive), increase patient centered focus and improve the safety of our patients.
    - Efficiency Theme – to improve efficiency, we must know our requirements and prioritize them. We must enhance the productivity of our system and improve our interoperability with our partners, both federal and private.
- External Customer Perspective – our customers want a fit and healthy force and quality care anywhere our beneficiaries may need it, but with increased customer service. We must also improve the health of our communities.

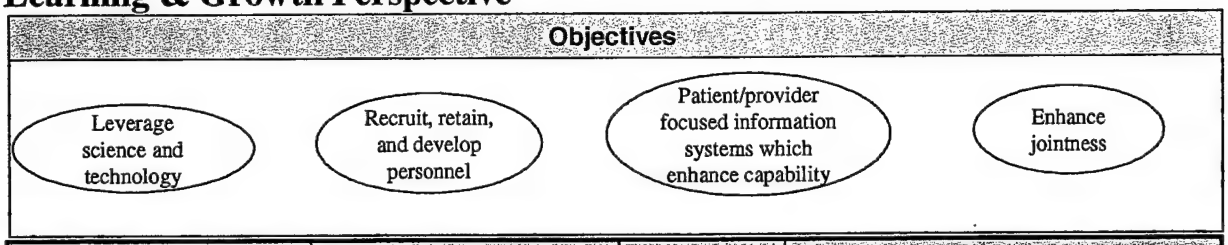
- Financial Perspective – we must determine and account for our readiness costs, continue to optimize the stewardship of our resources, and fight for the resources necessary to accomplish our mission.
- Stakeholder Perspective – our stakeholders demand that we provide health support for the full range of military operations and sustain the health of all those entrusted to our care.

Within each perspective, a table outlines the objectives, measures, targets and initiatives. Information describing each objective can be found below the table.

Strategic Alignment

Each of the three Services and HA/TMA performed a strategic alignment to show how current strategic, business, and performance plans aligned with the MHS scorecard.

Learning & Growth Perspective



Objective	Measures	Stretch Target	Initiatives
L&G-1: Leverage science and technology	% of R&D projects appropriately tied to strategic objectives	100%	-Bring metric results to attention of TARA Chairs and develop method to make them aware of MHS strategic objectives. -Define what we are trying to accomplish (define, link, communicate)
L&G-2: Recruit, retain, and develop personnel	-Fill rate (selected specialties) -Employee Satisfaction (unified survey)	-95% (critical shortages) -TBD	-Energize / resource ULB team to push incentives -Develop MHS program for recruitment and retention (potentially identifying policy issues and changes)
L&G-3: Patient/provider focused information systems which enhance capability	-% of patient encounters documented in the CHCSII system -Number of online appointments	-100% -7.5 million Appts	-Conduct limited deployment of the CHCS II system -Deploy TRICARE online
L&G-4: Enhance Jointness – optimize the way that we assign resources	# of unfilled MHS billets where other service overages exist	Zero	-Develop Tri-Service process for inter-Service resource sharing where possible and appropriate -Create a Task Force to make recommendations with milestones and plans to focus on Educational Experience, How we use flags, etc

- **L&G-1: Leverage science and technology**. This objective captures the areas of science and technology that are unique to the military medical mission or will enhance our ability to carry out our mission. The intent of this objective is for the MHS to take a leadership role in military medical research and development. A group will be formed and tasked with the responsibility of defining the scope of military medicine research and development, build a MHS vision, inventory the current research and development initiatives throughout the MHS and recommend prioritized requirements to the Senior Military Medical Advisory Council (SMMAC).

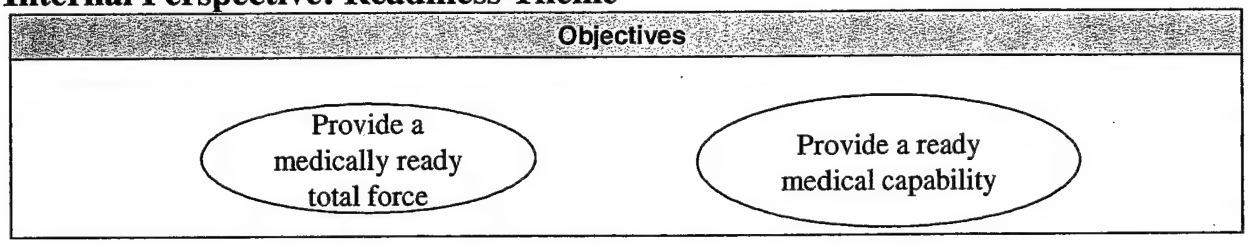
- **L&G-2: Recruit, retain, and develop personnel.** This objective includes the total force. The continuing education of senior MHS leadership is also contained within this objective as is the career development of all MHS personnel--military and civilian.

- **L&G 3: Patient/provider focused information systems which enhance capability.** This objective includes those systems that will support the MHS in meeting the other objectives contacted within our strategy. Since the implementation of CHCSII is vital to the success of the MHS, it was chosen

as the focus of this objective. TRICARE Online was added due to its potential to increase customer satisfaction.

- **L&G-4: Enhance jointness.** The intent is to create a culture of joint planning, training, and execution whenever possible. The focus of this objective will be on the sharing of personnel where appropriate.

Internal Perspective: Readiness Theme



Objective	Measures	Stretch Target	Initiatives
R-1: Provide a medically ready total force	-Individual medical readiness + Adequate (meets service regulations for deployability) + Optimal (deployable without medical intervention) -% completeness individual database entries	+80% of personnel medically ready to deploy +60% of personnel medically ready to deploy -95% database entries complete	-Develop, implement, and monitor individual medical readiness to deploy indicators -Develop, implement, and monitor individual medical readiness to deploy indicators for Guard and Reserve -Implement an integrated, comprehensive DoD medical surveillance system
R-2: Provide a ready medical capability	-% SORTS reportable OPLAN-tasked medical units reporting C1 or C2 -% requirements defined	-85 % of on-hand assets can execute tasking -90% defined	-Ensure policy development and financial influence supports OPLAN taskings -Define common core medical requirements for joint medical response operations, including related training, equipment and exercise standards

- **R-1: Provide a Medically ready total force.** This objective includes the total force; active, Guard and Reserve. This objective includes the responsibility on the part of the MHS to translate science into quality medical policy that is embraced by the force commanders and individuals within the armed forces. This objective acknowledges we are not the only parties responsible for delivering a fit and healthy, medically protected force. There are individual and command responsibilities; however, we will do our part to enhance force protection. This includes the health assessment of all military personnel, periodic monitoring their health status, surveillance for environmental/occupational health hazards and for medical outcomes, and providing both preventive and therapeutic health care services.

- **R-2: Provide a ready medical capability.** This objective includes the total force of active, Guard and Reserve. Also includes both personnel as well as

equipment platforms. This capability must be deployable, timely, and sustainable in order to meet the needs of our customers.

Internal Perspective: Quality Theme

Objectives

Improve patient safety

Increase patient-centered focus

Improve health outcomes

Objective	Measures	Stretch Target	Initiatives
Q-1: Improve patient safety	# of near misses (good catches) divided by total reported cases	TBD (no civilian benchmark available)	-Establish a process to share results of aggregate data analysis of near misses and actual events with both leadership and the field -Purchase and deploy Taproot across MHS -Link MedMARx between facilities and across services
Q-2: Increase patient-centered focus	- Satisfaction with encounter - Access (ease of getting an appointment)	90% (satisfied), 50% (hi satisfied) 80th percentile for civilian plans (MHS phone access—internal std)	-Establish process to examine benchmark organizations to (and) share successful techniques and ideas with leadership and the field. -Be the provider of choice for OB Services -Implement Access to Care OIPT recommendations.
Q-3: Improve health outcomes	# preventable admissions	Create a self benchmark	Establish a process to evaluate data and determine causes of any significant differences (positive or negative) between MHS and benchmark data

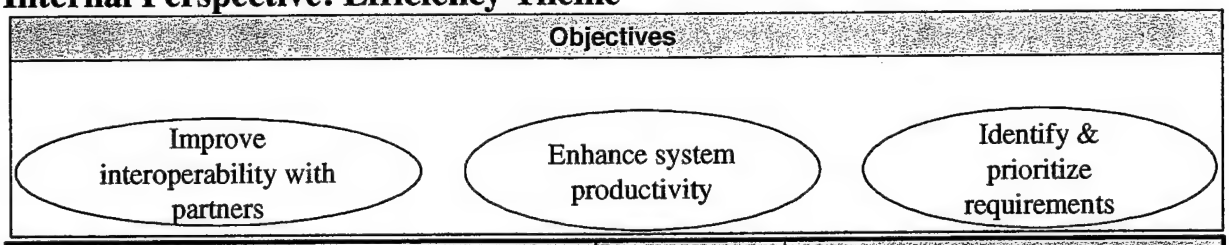
- **Q -1: Improve patient safety.** This objective includes risk management and patient safety education. Though patient safety is not a new issue, the use of near misses and sentential events in managing this program is not well established. Despite the fact that civilian benchmarks have not yet been established, the MHS should be on the cutting edge of data collection and analysis.

- **Q-2: Increase patient-centered focus.** The purpose of this objective is to put our patients at the center of everything we do. The financial incentive that once existed to use the direct care system is no longer present. In many cases, patients experience little, if any, out of pocket costs for obtaining care from a civilian provider. Superior patient-focused service must be our strategy for making the direct care system their provider of choice. Since the satisfaction with a health encounter begins with accessing the system, that is where the MHS will focus.

- **Q-3: Improve health outcomes.** The focus of this objective is population health. Our measure here is likely to reflect both access to the healthcare

system and the effectiveness of ambulatory and restorative care, each of which are elements of determining population health.

Internal Perspective: Efficiency Theme



Objective	Measures	Stretch Target	Initiatives
E-1: Improve interoperability with partners	-Number of Sharing Agreements -Joint Procurement Dollars	**TBD** $100Mil FY03	-Increase VA-DoD sharing agreements. -Increase VA-DoD joint procurement dollars.
E-2: Enhance System Productivity	-RVU per FTE -Clinical availability of provider -Hospital occupancy rate -Days per 1000 beneficiaries -Prime Leakage -Cost/RVU	= to or > 25 = to or > 80% = to or > 80% = or < 195 = to or < 30% **TBD**	-Develop, implement, and monitor provider availability, RVU/FTE and support staff/facility support standards. -Develop defined methodology and thresholds and monitor hospital occupancy and inpatient admission rates of MHS. Adopt bed counting methodology (e.g., CMS) -Develop methodology to assess prime leakage -Develop methodology and monitor cost of both direct and private sector care for MTF enrollees.
E-3 Identify & prioritize requirements	PA&E Study (completion of study and establish measures)	Staff and fund 100% of justified readiness requirements	Respond to PA&E Study by developing a methodology to staff and fund all justified readiness requirements

- **E-1: Improve interoperability with partners.** This objective includes all our private sector partners as well as our federal partners. Based on the preliminary recommendations of the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans, the relationship between DoD and Veterans Administration was selected as the focus of this objective. Included in the performance contract is a measure of our success with our claims processing partners.

- **E-2: Enhance system productivity.** The intent of this objective is to focus on the productivity of the system as a whole. The focus of this objective in the near term is to improve the efficiency of the direct care system.

- **E-3: Identify and prioritize requirements.** The intent of this objective is to make all requirements in the MHS visible (built from the ground up) and prioritized. The core team proposed and the leadership team agreed that no measures for this objective should be established until the PA&E study

(currently scheduled for release in November 2002), is available. The PA&E study will be used to drive the measures and initiatives within this objective.

Customer Perspective

Objectives			
Deliver a fit, healthy, and medically protected force	Deliver high quality care anywhere	Improve customer service	Build healthy communities

Objective	Measures	Stretch Target	Initiatives
C-1: Deliver a fit, healthy, and medically protected force	See R-1	See R-1	See R-1
C-2: Deliver high quality care anywhere	Industry-Based Quality Outcome Measures	-9 of the 9 metrics meet target	-Implement TRICARE Global Remote overseas healthcare contract -Clinical Quality Forum will develop and present a plan to improve the 9 quality measures -Implement Clinical Practice Guidelines across the MHS (90% of MTFs will implement the first 5 CPGs)
C-3: Improve customer service	Satisfaction with Health Plan	65% (Civilian 80 percentile) (21.2% Hi-Sat)	-Increase electronic submission of claims -Improve customer relations management strategy via T-Nex and new TIC contract
C-4: Build healthy communities	Population health 2010 metrics	Meet 9 of 9 metrics	-The Population Health Team will develop and present a plan to improve the 9 PHI metrics -Develop web-based population health support center

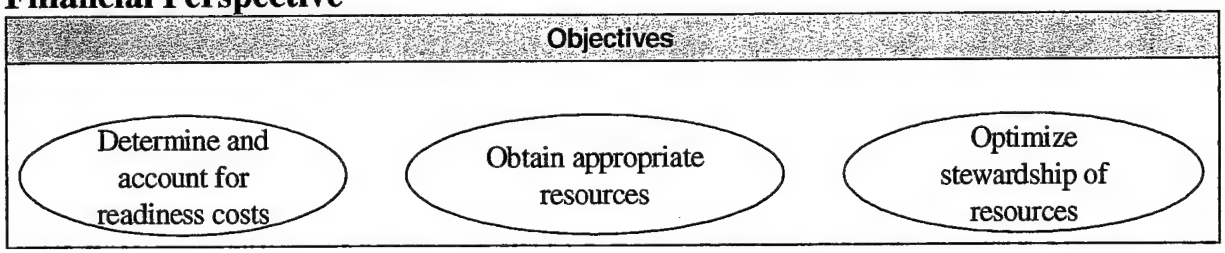
- **C-1: Deliver a fit, healthy, and medically protected force.** This objective acknowledges we are not the only parties responsible for delivering a fit and healthy, medically protected force. There are individual and command responsibilities; however, we will do our part to enhance force protection. The focus of this objective is to provide force commanders with information on the medical readiness of the force.

- **C-2: Deliver high quality care anywhere.** This objective includes the direct care system, care for our forces when they are deployed, and all our partners whether contract, federal or foreign national.

- **C-3: Improve customer service.** In recent years, Congress has provided increased options for our beneficiaries. Our beneficiaries now have increased power to vote with their feet, and the MHS must be more responsive to customer needs. Make the MHS the system of choice for our beneficiaries.

- **C-4: Build healthy communities.** This objective goes beyond restorative care and speaks to the need to institutionalize population health within the MHS.

Financial Perspective



Objective	Measures	Stretch Target	Initiatives
F-1: Determine and account for readiness costs	-Cost of Readiness	**TBD**	Identify specific readiness related costs and resolve any disconnects between the top down and bottom up review of financial data and respond to PA&E Study.
F-2: Obtain appropriate resources	-% of DHP budget growth within accepted national healthcare inflationary index - real property life-cycle maintenance and capital equipment maintenance	-Annual growth DHP aligns w/ Annual Growth of Medical consumer Price Index (MCPI) -Bldg 30 Years, Maj Equip 7-10 Years, Minor Equip 3-5 Years	-Identify health care resource requirements based on historic trends and industry forecasts to assist budget development. -Develop methodology and provide report of MHS facilities and equipment replacement timelines consistent with health care industry benchmarks.
F-3: Optimize stewardship of resources	-Healthcare Efficiency of the MHS ($ output/ $ input) -Healthcare Efficiency of the Direct Care System ($ direct care output/ $ direct care input)	**TBD** **TBD**	Increase the care/cost ratio of MHS and DCS

- **F-1: Determine and account for readiness costs.** The intent of this objective is to get visibility over all readiness costs to include Guard and Reserve and then appropriately account for how those dollars are spent. Since a significant portion of the readiness costs are not contained within the DHP, this will require a coordinated effort with our line counterparts.

- **F-2: Obtain appropriate resources.** Once requirements have been identified and prioritized, it is the MHS senior leaderships' responsibility to make the case for obtaining the appropriate resources to support the MHS mission.

- **F-3: Optimize stewardship of resources.** This objective includes both the direct care system and private sector care. The intent of this objective is to provide visibility and accountability of all MHS resources.

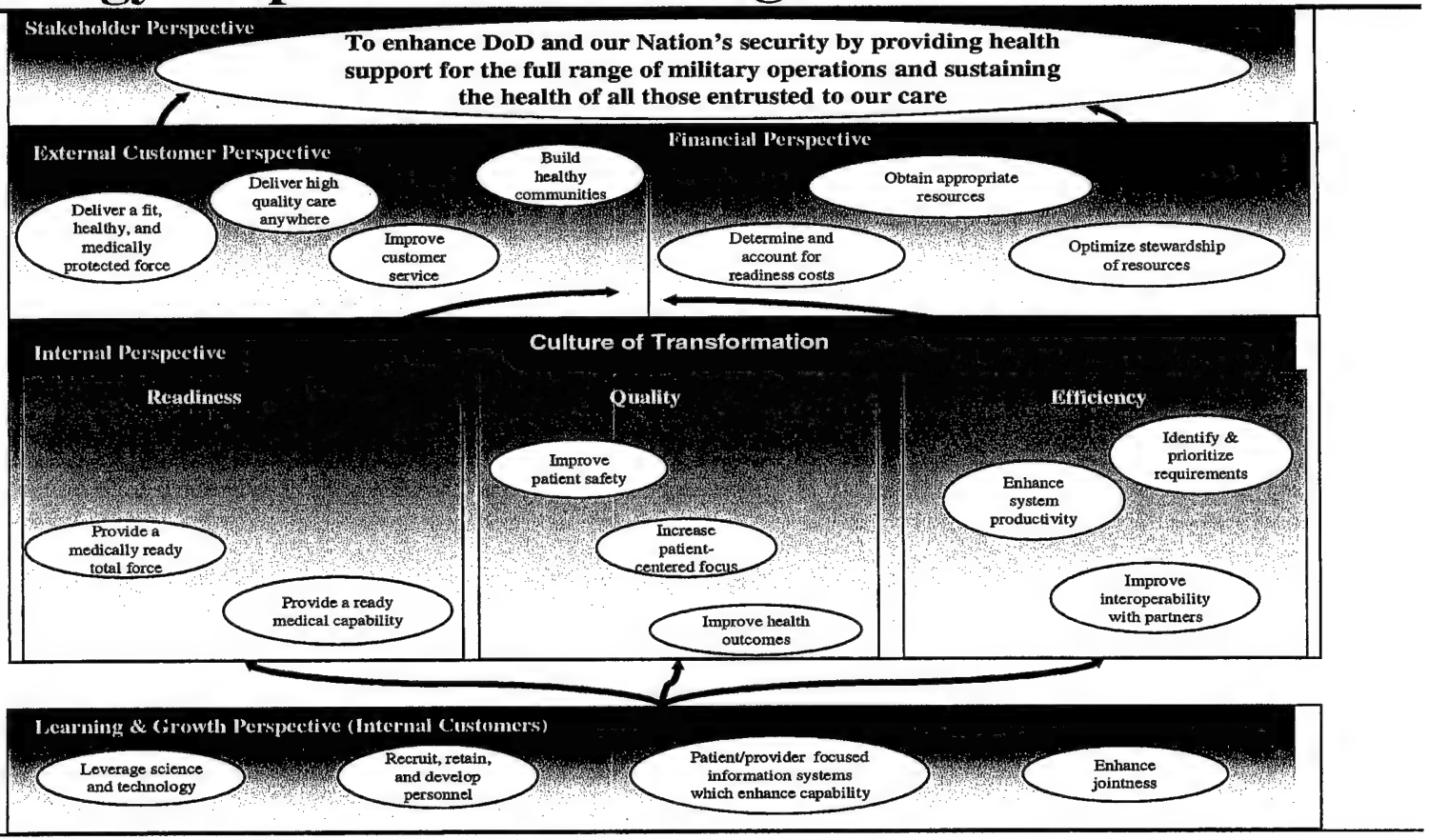
Stakeholder Perspective

Objectives
To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care

Objective	Measures	Stretch Target	Initiatives
S-1: To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care	JCS satisfaction with medical support	24 star endorsement of medical program	Produce a validation document for service chief signature

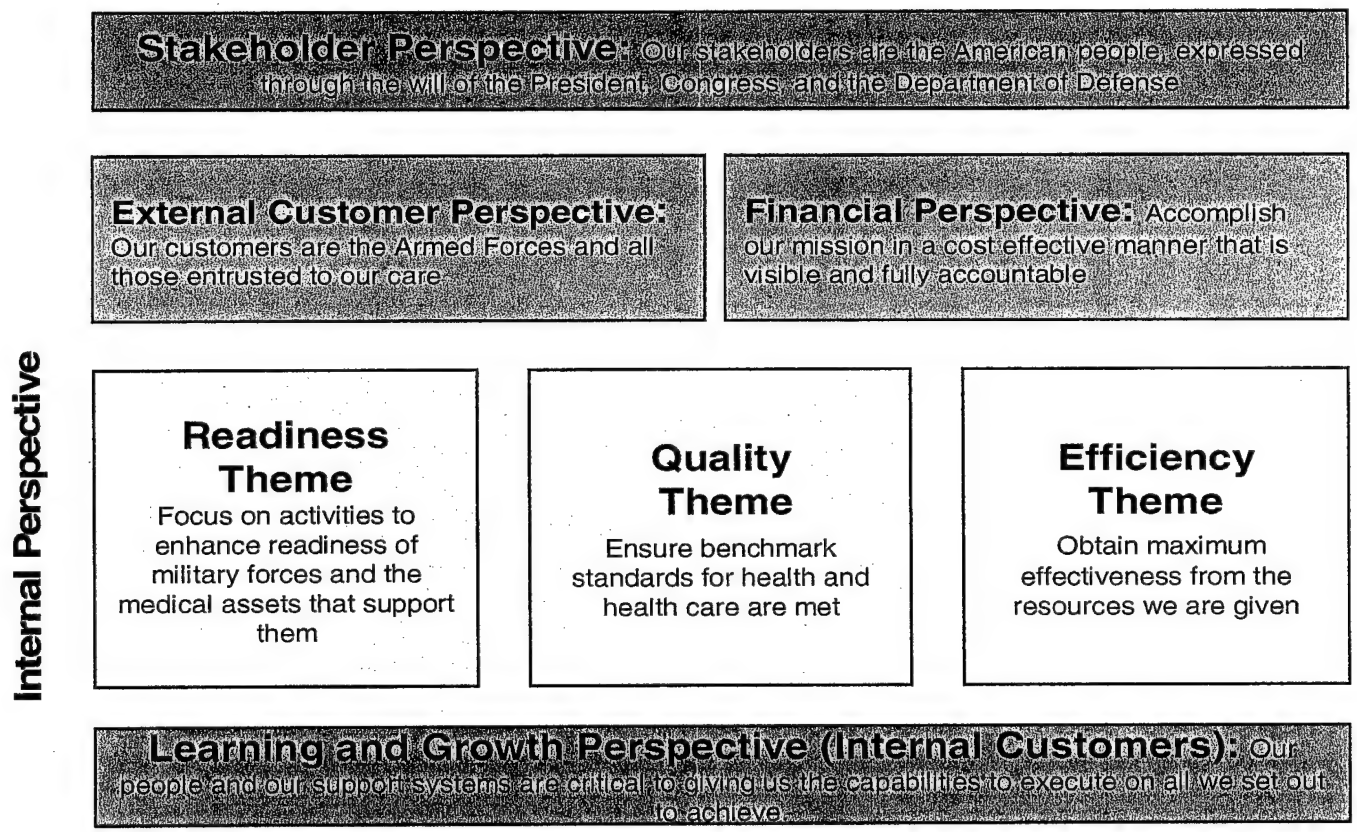
- **S-1: To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.**

Strategy Map for Transforming the MHS



Appendix 1

MHS Strategy Architecture



Performance Contract
Between
Defense Resources Board
and
Assistant Secretary of Defense (Health Affairs)
FY 2003-2008

I. Introduction

Preamble. This contract is between the Defense Resources Board (DRB) and the Assistant Secretary of Defense, Health Affairs (ASD(HA)) along with the Army, Navy and Air Force Assistant Secretaries for Manpower and Reserve Affairs. Its purpose is to articulate expectations for the performance of the Defense Health Program (DHP) from FY 2003 through FY 2008. Nothing in this contract is intended to alter the basic mission, operations, authority, or reporting chain of the ASD(HA) or the Military Departments. The Under Secretary of Defense, Personnel and Readiness (USD(P&R)), as the principal staff assistant (PSA) for the DHP, is the agent of the Deputy Secretary of Defense responsible for implementation of the contract and for all direction associated with its implementation. The PSA is responsible for all direction stemming from DRB reviews of the program's performance against the contract targets.

The standards and goals in this contract were based on the assumption that the DHP will continue operations in an overall peacetime environment with a likelihood of providing support for peacekeeping, humanitarian, and contingency operations at levels similar to those in recent years. Given the terrorist act of September 11, 2001 and the activities that will follow, some of these assumptions are subject to change. It is the responsibility of the ASD(HA) to notify the DRB promptly, through the USD(P&R), if changing conditions make any terms of this contract impossible or impractical to fulfill. The ASD(HA) will propose modifications, as necessary, to accommodate direction from the Secretary or Deputy Secretary of Defense.

Product Lines and Customers. The ASD(HA) is charged with the operation of the Defense Health Program and serves as principal advisor to the Secretary of Defense for medical and health affairs. As such, the ASD(HA) has direct operational responsibilities as well as oversight responsibilities in areas where operational responsibilities are held by others.

For the purposes of this contract, the major product line of the DHP is Medical and Dental Care.

Medical and Dental Care. The provision of health care consumes the vast bulk of the DHP's resources. Health care is provided in military treatment facilities (MTFs)

operated by the Department of Defense (DoD); through TRICARE managed care support contracts; and in the form of other health care purchased by the DHP (principally care provided in the former public health hospitals, known as designated providers, and care purchased in civilian facilities for active-duty personnel). These sources of care are collectively referred to as the Military Health System (MHS).

Customers for health care include the military departments and the individual beneficiaries themselves. A primary component of the health care mission for active duty personnel is medical readiness, where the ASD(HA) is charged with maintaining a fit and healthy active-duty force and ensuring the deployability of all medical units. The customers are the military departments and the unified commanders. In addition to the medical and dental care provided to active-duty personnel, the military departments have an interest in the health care received by active-duty dependents, to the extent that family matters affect the morale and performance of active-duty personnel. The medical and dental care benefit is also valued by the eligible beneficiaries.

Relationship to DHP Strategic Plan. This contract is consistent with the strategic plan for the DHP, entitled the Military Health System Strategic Plan, which stresses the importance of readiness, quality health care, and training.

II. Business Area Performance Standards

BUSINESS AREA: MEDICAL AND DENTAL CARE

The ASD(HA) has projected workload and resources for the provision of health care for FY 2003-2008 as shown below[1].

Defense Health Program—Workload & Resources

	FY01	FY02	FY03	FY04	FY05	FY06	FY07
DHP Funded ($M)	14,362	20,672	14,413	15,011	15,592	16,057	16,516
Beneficiaries (000)	8,149	8,158	8,173	8,201	8,233	8,264	8,264

Historically, the DHP measured the allocated cost per user. However, the expansion of eligibility for TRICARE for Medicare eligible beneficiaries in FY 2002, as well as the establishment of an accrual fund to pay for this expansion in FY2003, make this particular metric meaningless.

[1] The FY 2000 National Defense Authorization Act expanded TRICARE benefits to Medicare-eligible retirees effective FY 2002 and directed the establishment of an accrual fund to pay for the new benefit beginning in FY 2003.

Unit Cost and Productivity Metrics

1. In FY 2003, the number of Work Relative Value Unit visits per Full-time Equivalent (FTE) provider per 8-hour day in US military primary care clinics shall exceed 13.4, the FY01 result was 13.3. (Note: Nurse Practitioner and Physician Assistant FTEs will be counted as a .75 provider FTE.)
   Data Source: All Region Server (SADR) and EASIV **Report Frequency:** Quarterly

2. In FY 2003, the total number of Primary Care and Specialist Work Relative Value Unit visits seen in military clinics shall exceed 33 million, in FY00 there were 30.5 million, and in FY01 32.4 million
   Data Source: All Region Server (SADR) **Report Frequency:** Quarterly

3. In FY 2003, the percentage of MHS visits delivered in the direct care system within United States catchment and clinic areas for beneficiaries under 65 shall exceed 74% percent. The FY 1999 marketshare was 80 percent, the FY 2000 marketshare was 79 percent, and the FY 2001 estimate is 77 percent.
   Data Source: All Region Server (WWR, HCSR) **Report Frequency:** Quarterly

4. In FY 2003, the total number of Relative Weighted Product adjusted dispositions seen in military hospitals shall exceed 246 thousand, in FY 2000 there were 268 thousand, and in FY 2001 there were 253 thousand.
   Data Source: All Region Server (SIDR) **Report Frequency:** Quarterly

5. In FY 2003, the percentage of MHS Relative Weighted Product adjusted dispositions delivered in the direct care system within United States catchment areas for beneficiaries under 65 shall exceed 64 percent. The FY 1999 marketshare was 70 percent, the FY 2000 marketshare was 69 percent, and the FY 2001 estimate is 67 percent.
   Data Source: All Region Server (SIDR, HCSR) **Report Frequency:** Quarterly

6. In FY2003, the number of bed days per 1000 enrollees under age 65 (excluding newborns, mental health and substance abuse) shall not exceed 216. The FY1999 rate was 199, the FY2000 rate was 202, and the FY2001 estimate is 216.
   Data Source: All Region Server (SIDR,HCSR,DEERS) **Report Frequency:** Annual

7. In FY 2003, the cost of purchased care services within United States catchment areas for beneficiaries under 65 shall not exceed $1.68 billion. The FY 1999 cost was $1.0 billion, the FY 2000 cost was $1.1 billion, and the FY2001 projection is $1.2 billion.
   Data Source: All Region Server (SIDR, HCSR) **Report Frequency:** Quarterly

Terms and Conditions: The values for each of the Service Departments can be found in the Appendix 1, along with the description of the metric. Where possible the metrics follow the MHS Executive Report measures, and will be reviewed for appropriateness by a metric oversight group, established by the ASD(HA). Historically, the MHS measured visits with no adjustments for the intensity of those visits. The introduction of Standard Ambulatory Data Records with clinical information now allows for adjusting those visits using Relative Value Units (RVUs) based on Center for Medicare and Medicaid Services (CMS) developed methodology. Visit Market Share goals for FY 2003 were based on results from first two quarters in FY 2002, and may be adjusted to a RVU weighted market share when RVUs are available in the purchased care data. Primary care clinics as defined for metric 1 can be found in Appendix 1. Purchased Care data is projected to completion for metrics 3, 5, 6, and 7. Workload metrics for the direct care system assume stability of personnel. Actual endstrengths as well as availability of personnel for work in MTFs will be monitored quarterly and adjustments in these goals may be necessary. Purchased care cost increase is based on a 12% program and inflation increase over the FY 2002 goal.

Quality and Customer Responsiveness Metrics

1. In FY 2003, the ASD(HA) shall ensure that the average grid score awarded to DoD MTFs by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is higher than the civilian average. The average grid score for all MTFs accredited during FY 1999 was 95.2 with civilian average of 90.7, FY 2000 was 94.4, and FY2001 was 92.6.
   Data Source: JCAHO **Report Frequency:** Annual

2. In FY 2003, satisfaction ratings of care received in military treatment facilities, reported quarterly, shall achieve 90 percent or greater. The FY 1999 actual was 88.8 percent, the FY 2000 actual was 89.2 percent, and the FY2001 actual was 88.5 percent.
   Data Source: Customer Satisfaction Survey **Report Frequency:** Quarterly

3. In FY 2003, the number of DoD beneficiaries delighted with their health plan shall exceed the civilian average (54 in FY01). The FY 2001 MHS actual was 43.
   Data Source: Health Care Survey of DoD Beneficiaries **Report Frequency:** Quarterly

4. In FY 2003, the number of TRICARE Prime enrollees (excluding TRICARE Plus) within the United States will exceed 3.74 million. At the end of FY1999, there were 2.84 million enrollees, at the end of FY 2000 there were 3.51 million enrollees, and at the end of FY 2001 there were 3.58 million enrollees.
   Data Source: All Region Server (DEERS) **Report Frequency:** Quarterly

5. In FY 2003, a Diagnosis Related Group (DRG) weighted index of conditions that need not result in admission to hospitals shall not exceed 1.6 relative weighted products (RWPs) per 1,000 active-duty personnel or 7.0 RWPs per 1,000 non-active duty enrollees. The active duty rate for FY 1999 was 1.7 per 1000, FY 2000 1.8 per 1000, and FY2001 1.8 per 1000. The non-active duty enrollee rate for FY 1999 was 7.5 per 1000, FY 2000 rate was 7.5 per 1000, and the FY2001 rate was 6.8 per 1000.
   Data Source: All Region Server (SIDR, HCSR, DEERS) **Report Frequency:** Annual

Terms and conditions: The values for each of the Service Departments can be found in the Appendix 1, along with the description of the metric. The current list of preventable admissions for active-duty personnel and active-duty family members is presented at Appendix 1. Where possible the metrics follow the MHS Executive Report measures, and are being reviewed by a metric oversight group for appropriateness. ***Note: All measures from the Monthly Customer Satisfaction Survey are based on old sampling methodology, and as a result goals may need to be adjusted once data is available. Additionally, a new survey instrument is currently being investigated, and if this new instrument is selected, new goals will need to be established.***

Access Metrics

1. In FY 2003, 83 percent of prime enrollees shall report satisfaction rates of at least "good" regarding ease of making appointments by phone. The FY 1999 satisfaction rate was 83 percent, FY 2000 was 82 percent, and FY 2001 was 82 percent.
   Data Source: Customer Satisfaction Survey (MHSES) **Report Frequency:** Quarterly

2. In FY 2003, the percentage of "clean" claims processed within 30 days within each region shall meet or exceed 95 percent. The FY 1999 actual was 85 percent, the FY 2000 actual was 97 percent, and the FY 2001 actual was 98 percent.
   Data Source: Contractor Reports (MHSES) **Report Frequency:** Quarterly

Terms and Conditions: The values for each of the Service Departments can be found in the Appendix 1, along with the description of the metric. Where possible the metrics follow the MHS Executive Report measures, and are being reviewed by a metric oversight group for appropriateness.

Population Health Performance Metric

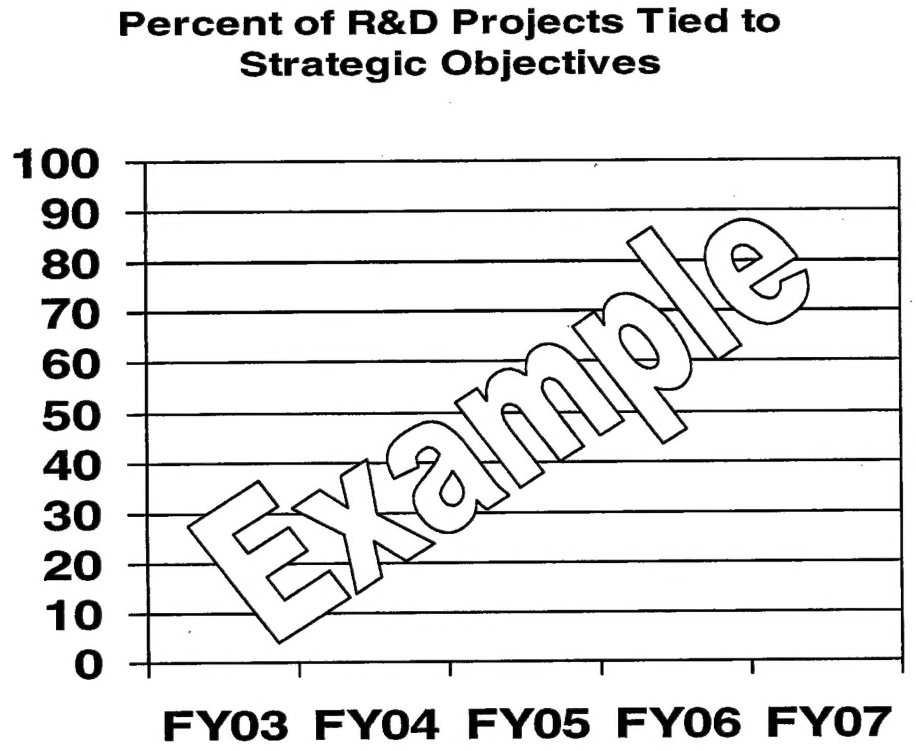
1. In FY 2002, the Healthy People 2010 index of public health function performance shall be at least 71.0. The baseline for FY99 was 66.6 and for FY00 was 70.6.

Data Source: Health Care Survey of DOD Beneficiaries, SIDR **Report Frequency:** Annual

Terms and Conditions: Many components of the public health metric are beyond the scope of DHP control. The ASD(HA) serves as the "public health champion." For the public health areas not directly under the control of the ASD (HA), performance will be judged on oversight and advocacy of the military services' role in promoting health lifestyles and public health. Goals from Healthy People 2010 are presented in Appendix

L&G-1 Report - % of R&D Projects Tied to Strategic Objectives

Perspective	Learning and Growth
Objective Owner	LTG Peake/Mr. Reardon
Measure Leader	Dr. Sal Cirone (FHP&R)



Performance Analysis:
Percentage of Defense Technical Objectives reviewed by the ASBREM that align with MHS strategic objectives

Target:
- 03 = establish baseline, 07=100%

Measures Definition:
- **Purpose:** Drive linkage between R&D and strategic Planning
- **Data Source:** TARA Chairs, ASBREM
- **Frequency:** Annual
- **Calculation method:** Percentage

Strategic Objective:
This objective captures the areas of science and technology that are unique to the military medical mission or will enhance our ability to carry out our mission. The intent of this objective is for the MHS to take a leadership role in military medical research and development.

Business Initiatives:
-Establish definition, goals, objectives and vision
-Develop S&T agenda
-Inventory current initiatives and establish a baseline
-Link R&D and policy
-Link to TARA and educate Chairs on MHS strategic objectives